HEALTH AND WELLBEING BOARD APRIL 2014

Title of paper:	**Primary Care Vision**	
Director(s)/ Corporate Director(s):	Maria Principe	**Wards affected:**
Report author(s) and contact details:	**Maria Principe, Director of Primary Care Development and Service Integration**	
Other colleagues who have provided input:	**As per stakeholders listed within document**	
Date of consultation with Portfolio Holder(s) (if relevant)	**N/A**	

Relevant Council Plan Strategic Priority:	
Cutting unemployment by a quarter	☐
Cut crime and anti-social behaviour	☐
Ensure more school leavers get a job, training or further education than any other City	☐
Your neighbourhood as clean as the City Centre	☐
Help keep your energy bills down	☐
Good access to public transport	☐
Nottingham has a good mix of housing	☐
Nottingham is a good place to do business, invest and create jobs	☐
Nottingham offers a wide range of leisure activities, parks and sporting events	☐
Support early intervention activities	☐
Deliver effective, value for money services to our citizens	☐

Summary of issues (including benefits to citizens/service users):

Improved access to primary care
Standardised access to primary care services
Support to self-refer

Attached are an executive summary, presentation and the full plan.

Recommendation(s):	
1	The strategic vision is built on a compelling case for change with a clear set of reasons for improvement in order to deliver high quality and equitable primary care services that improve patient outcomes. The Commissioning Executive Group is asked to comment on the vision

1. REASONS FOR RECOMMENDATIONS

As per strategy.

2. BACKGROUND (INCLUDING OUTCOMES OF CONSULTATION)

As per strategy.

3. OTHER OPTIONS CONSIDERED IN MAKING RECOMMENDATIONS

4. FINANCIAL IMPLICATIONS (INCLUDING VALUE FOR MONEY/VAT)

5. RISK MANAGEMENT ISSUES (INCLUDING LEGAL IMPLICATIONS AND CRIME AND DISORDER ACT IMPLICATIONS)

N/A

6. EQUALITY IMPACT ASSESSMENT

Has the equality impact been assessed?

Not needed (report does not contain proposals or financial decisions)	X
No	☐
Yes – Equality Impact Assessment attached	☐

Due regard should be given to the equality implications identified in the EIA.

7. LIST OF BACKGROUND PAPERS OTHER THAN PUBLISHED WORKS OR THOSE DISCLOSING CONFIDENTIAL OR EXEMPT INFORMATION

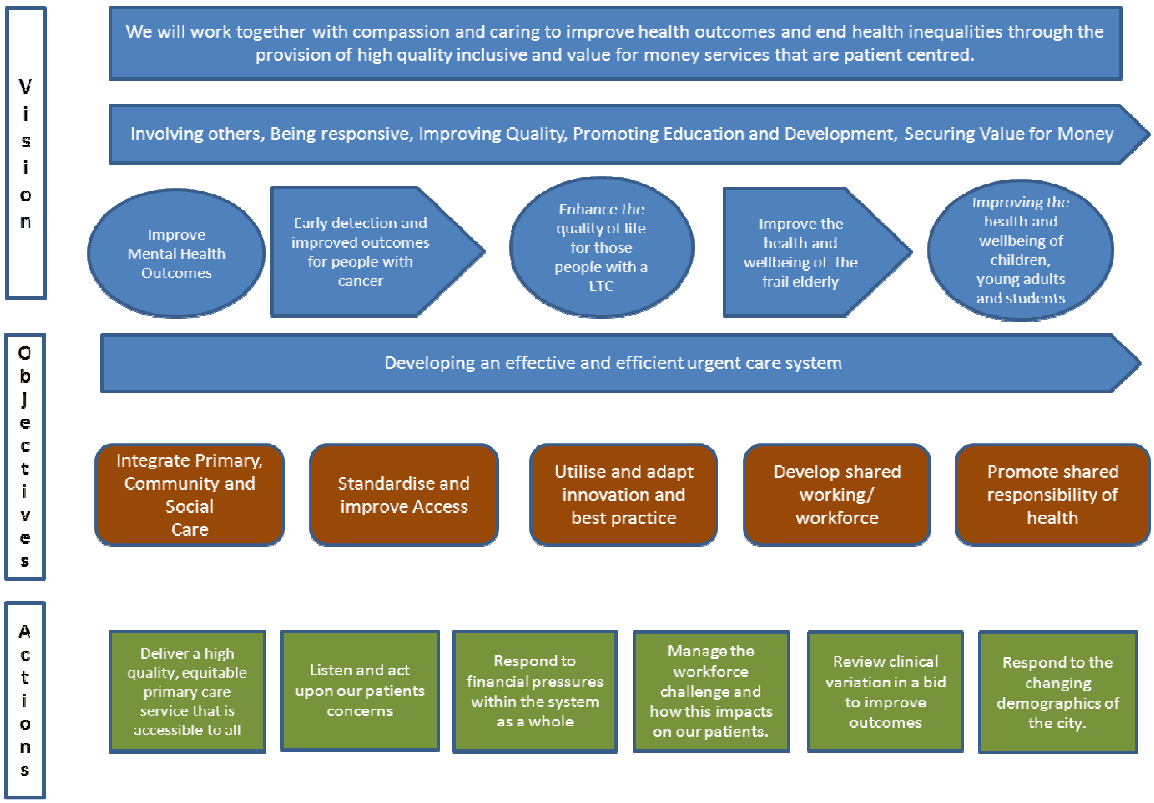
8. PUBLISHED DOCUMENTS REFERRED TO IN COMPILING THIS REPORT

Primary Care Vision

Introduction

This aim of this paper is to articulate and to introduce to the Commissioning Executive Group the Clinical Commissioning Groups future vision (see appendix 1) for primary care, specifically General Practice which is built on five essential objectives identified within the plan on a page in diagram 1. The key objectives for primary care for 2014-2015 are to:-

- Integrate Primary Community and social care
- Standardise and improve access
- Utilise and adapt innovative technology and best practice
- Develop shared workforce/working
- Promote shared responsibility of health



It is recognised that this vision cannot stand alone; therefore it should be implemented within the context of the CCGs Adult Integrated Care vision, Urgent Care Plan, Operating Framework, Patient Involvement and Challenge Fund requirements and IT framework.

Background

In 2013/14 the NHS in England spent more than £11 billion on primary care services. Primary care has long been identified as a particularly important determinant of access, quality improvement and equity[1].

Primary Care is at the heart of the NHS accounting for around 90 per cent of all patient contact and is the gateway to secondary care, and is both the start and the end point of most

[1] Future Challenges for Primary Care, Kings Fund, 2013

patient journeys.A strong and effective primary care is acknowledged to be a critical component of a high-performing health care system. This is based on the principle that high quality primary care improves health outcomes and helps contain health care costs.

NottinghamCity has a very diverse population with different needs who require a wide range of services from primary care providers. There is also a significant amount of variation in the provision both in size and quality of service provision. Our clusters are seeing a higher than expected use of costly hospital services. Some of the services have potential to be more appropriately provided in a primary care setting. Better primary care provision will contribute to addressing the life expectancy across the city.

Primary care is key to delivering a cost-effective health care system for our population. Primary care is the first point of contact for more than 90% of our patients and service-users in accessing care. Primary Healthcare teams play a crucial role in chronic disease management, health promotion, diagnostics and early intervention, and treatment information management.

Through clinical commissioning, GPshave a shared financial responsibility hold for many local NHS services however this also puts them in a potential position of conflict as local independent providers. In developing our primary care objectives, we recognised this conflict and looked at what primary care should look like from the eyes of our patients. In doing this, we are able to transparently develop a vision and objectives strategy that meets the needs of our patient population.

Drivers for Change

NHS Nottingham City Clinical Commissioning Group (CCG) has achieved much over the last few years and has developed a robust working partnership with our member practices, challenges in workforce combined with increasing demand from older and frail patients living with complex and multiple long term conditions and other vulnerable groups such as those with mental health problems, and the deprivation that exists within the city has resulted in the CCG reviewing its primary care provision with a view of developing a vision that focuses on quality improvement.

The drivers for the attached primary care vision are:-

Improve the quality of primary care - General practice is seen as the bedrock of the health care system. Patient surveys highlight high levels of trust in GPs and an overall level of satisfaction with the services received in general practice. The primary care performance dashboard and Quality Performance indicators identifies areas of excellence in the provision of primary medical services, but we also have other areas where the quality falls below expected standards, these are monitored through Quality Outcomes Framework and local and national performance dashboards. Nottingham City CCG has increased its focus on quality improvement in recent years, with greater availability and sharing of data and information through e-healthscope, and peer review of practicesvia the practice visit programme. Nottingham also aims to make greater use of evidence-based clinical guidelines and decision-support aids through the procurement and development of a bespoke pathways database. However for future success it is It is key that practices are supported and encouraged to seek out and address variable performance and see these reviews as the 'norm' in improving primary health care provision.

Reduce health inequalities - In overall terms the City's residents are less healthy than elsewhere in the country. Life expectancy in Nottingham for men is 75 years, compared with 78 for Greater Nottingham and for England, and for women 80 years compared with 82 for Greater Nottingham and Englandhttp://www.nottinghaminsight.org.uk/insight/jsna/jsna-

executive-summary.aspx - _ftn5. The gap in life expectancy between Nottingham and England has been widening since the early 1990s.http://www.nottinghaminsight.org.uk/insight/jsna/jsna-executive-summary.aspx -_ftn6Within the City there are high levels of health inequalities – life expectancy varies by ten years between the most and least deprived wards of St Ann's and Woollaton West. 15 of the 20 wards have significantly lower life expectancy than the regional average. The most significant disease contributors to our lower than average life expectancy are premature deaths caused by cardiovascular disease (CVD), respiratory diseases and cancers.

Improve the inequity in primary care provision - The GP contract and previous approach to Local Enhanced Services has resulted in fragmentation of service provision. This has resulted in inequity of provision for basic services such as Treatment Room and ECG. In meeting this inequity and improving access and choice specific primary care services will need to be opened up to more providers, improving access to treatment and offering patients greater choice.

Mitigate local and national workforce challenges - The Centre for Workforce Intelligence, the national workforce planning body in England, is forecasting an oversupply of hospital doctors and an undersupply of GPs. Therefore across NottinghamCity the demand for health and social care workers is growing, but the number of workers is not. The resolution to these challenges cannot develop locally, however in the interim, the vision must identify an approach that will bridge the gap until education and training leads are able to identify a national direction and solution. "Most of the professionals who will be working in the NHS in ten years' time are working in the NHS today. Any workforce redesign needs to focus more on re-training or re-assigning/re-purposing the current workforce, so that they have the skills needed to deliver new models of care"(Kings Fund, 2013)

Integrating Care- The current workforce is trained and developed to work in a model centred around single episodes of treatment in hospital. It is now more evident that those patients placing the greatest demand on services, both now and in the future, are older people with multi-morbidities (both mental and physical), who need integrated, long-term health and social care treatment, complimenting the adult integrated care programme. The vision must recognise this shift change and work within the remit of integrating care.

Develop a modern NHS - It is anticipated that new information technology systems will enable different ways of working, including enhanced roles for patients, ultimately changing how the workforce operates. Technology within the vision will need to enable patients to have more control over the management of their health, supporting them to thrive outside of a hospital setting.

Meet the Quality Innovation Productivity and Prevention (QIPP) Challenge **-** QIPP is a large-scale programme developed by the Department of Health to drive forward quality improvements in NHS care. QIPP represents a broad, policy agenda rather than a single, definable policy. There are a number of national workstreams within QIPP designed to support the NHS to improve care and lower costs. These range from improving commissioning (or purchasing) of care for patients with long-term conditions, to improving how organisations are run, staffed and supplied. Nottingham City's QIPP plan for 2014/15 assumes an increasing level of shift of care from acute services into community and primarycare service, therefore it is essential to ensure that the primary care vision enables the local community to respond to this strategic shift change.

Vision Development

The following steps have been taken to develop this vision:

1. Engage with patient and public forums to understand what a quality primary care service looks like.
2. Engage with clinicians to understand clinical approach to quality improvements
3. Undertake an analysis of current quality, variation, capacity, capability and assess against desired levels

1. <u>Engage with patient and public forums to understand what a quality primary care service looks like</u>

Nottingham City has gained insight into the views of patients and the public. In September 2013 the CCG began to ask patients and stakeholders how best to develop primary care services. Questions were developed via the People's Council in which patients designed the questions to ask other patients. This was then developed into an online survey to gain further feedback, together with paper surveys and questionnaires sent to GP Practices and forums such as help the aged, asylum seeker groups and other voluntary organisation. The following engagement has taken place:-

- Attendance and discussion at Patient Council.
- Production and distribution of online surveys
- Production and distribution of paper survey distributed to practices
- Utilisation of social media, including Twitter and Facebook
- Online survey sent to key stakeholder groups
- Feedback from patient representatives at cluster groups.

In engaging with our patient and citizen population we have identified that:-

- Patients expect the NHS to utilize modern technology
- More development to adopt GP telephone triage where appropriate to streamline access
- Consistent approach to access to remove inequity for city based population
- Expectation that the NHS is sharing information and data to improve care
- Practice receptionist role developed to signpost patients to most appropriate service (not act as a gatekeeper to the GP).
- Saturday access is viewed positively
- Limited interest in Sunday access

2. <u>Engage with clinicians to understand clinical approach to quality improvements</u>

This vision has its origins in an intensive period of dialogue with Primary Carepractitioners. With the support of CCG Clinical and non Clinical Executives – we have:-

- Attended cluster board meetings, to obtain local dialogue on key concerns regarding current challenges and future needs
- Linked through our education lead to national forum and discussions on the wider remit in relation to workforce and development
- Fed back and sought guidance from Bi-annual meetings
- Presented findings and recommendations via the CCGs clinical Council meeting
- Engaged with the local Area Team and shared the vision with key commissioning leads to raise awareness of its conception

In engaging with our members we have identified that:-

- The current shift in work is having a significant impact on primary care, however concerns are raised as practitioners are seeing a shift in work but not in resources
- Financial management / competition / contract changes - The majority of practices are inexperienced in bidding and competing for business, which could have a detrimental effect on primary care provision
- Communication overload from all sectors
- Workforce retention, retiring GPs, shortage of primary care clinicians is having an impact on provision
- Variations in service delivery/community services is impacting on equity of provision
- Managing patient expectations.

3. Undertake an analysis of current quality, variation, capacity, capability and assess against desired levels

The CCG has a statutory duty to assist the NHS Commissioning Board in continually improving the quality of local primary medical care services and ensuring that the commissioning finances of the CCG are managed. Within the Inter Practice Agreement the Primary Care Development and integration team have been delegated the responsibility of working supportively with member practices to implement any required quality improvements. These are identified via the Primary Care Performance and Quality Group (PCPQG), in which primary care performance is viewed by utilising local and national dashboards. These dashboards enable the CCG to understand how general practice is performing on delivering the CCGs strategic indicators as well as indicators identified via the national primary care framework.Where practices are identified as an outlier the PCPQG triangulates activity and performance data alongside practice visit feedback and patient comments and where required carries out a deep dive review. This triangulation of information enables the CCG to identify variation, capability and capacity issues noting where quality can be improved and best practice communicated. Findings to date have identified:-

- Practice are having to close their list due to increases in demand
- Patients are opting to travel for a preferred GP
- Variation and approach to clinical pathways is impacting on activity
- Clinicians not using commissioned pathways as they are unaware of them
- Choose and book has created a divide in communication between GP and consultant
- Variation in approach to access
- GPs feel the route to ask for advice and guidance has been removed

During this engagement process a theme emerged that demonstrated the need for a more integrated way of working, enabling practices who wish to do so to support one another, working geographically within care delivery groups to enable the population of the City to have access to similar range and quality of services. This theme has been merged into the vision.

Summary

Primary care, and in particular care delivered by general practice has been a cornerstone of the NHS since its inception. Its delivery model has evolved through the years but potentially faces its greatest challenge. These challenges within primary care are of significant scale, complexity and risk to have a real impact on Primary Care provision, therefore the aim of the attached vision is to develop sustainable changes by supporting and enabling change to internal systems such as access, workforce and outcomes.

Whilst GP services are commissioned by NHS England, it is imperative that Clinical Commissioning Groups support and encourage the development of primary care services as our GP members play an important role in influencing this vision, and implementation will only succeed with the clinical ownership of GPs working in conjunction with health partners.

Recommendation

Our strategic vision is built on a compelling case for change with a clear set of reasons for improvement in order to deliver high quality and equitable primary care services that improve patient outcomes. The Governing body is asked to comment on the vision

NHS
Nottingham City
Clinical Commissioning Group

Working together for a healthier Nottingham

A primary care plan for Nottingham City

Dr Hugh Porter
Chair, Nottingham City CCG

Maria Principe, Director Primary Care Development and Service Integration
NHS Nottingham City CCG

March 2014

1. Executive Summary

This is a first draft of NHS Nottingham City Clinical Commissioning Group's (CCG) future vision for primary care, and specifically General Practice. This document is a result of extensive engagement with primary and community front line clinicians, our patients and our public. It is a document that will need to flex and change to meet the needs of our diverse population It takes into account national policy and guidance on how primary care should be developed alongside patient views and surveys on the needs and preferences of our local population. This document aims to present a primary care plan on how primary care services might be developed in Nottingham City and is a first step and builds on our engagement with clinicians, colleagues and partners. We know the links to other primary care contractors and healthcare commissioners will be essential in delivering a comprehensive service and we will build on this vision to with all stakeholders to ensure it is fully inclusive'. This primary care plans is built on five essential objectives (as seen on the plan on a page):

- Integrate Primary Community and social care
- Standardise and improve access
- Utilise and adapt innovative technology and best practice
- Develop shared workforce/working
- Promote shared responsibility of health

1. <u>The reasons for change are:</u>

- We need to improve the health and wellbeing of the citizens of Nottingham City and reduce health inequalities
- We want to deliver a high quality health service that is accessible and places care and compassion at its heart
- We need to be in a position to manage the changing patient demographics of Nottingham City that are placing greater demand on local health and social services
- We need to respond to significant financial pressures in health and social care
- We must respond to our patients concerns regarding access and choice.
- We must pre-empt the workforce challenges in general practice to mitigate the impact on our patients.

2. <u>Where are we now?</u>

- We have a vibrant and dynamic CCG and our membership understands its role as commissioner of health services
- The CCG has formalised its strategy for the next. 3 years and needs effective General Practice (GP) services to help deliver this
- Across our four clusters of GP Practices we have examples of excellence in primary health care delivery; however, we also have significant variance in terms of patient experience, clinical quality of care, and varied provision of services between practices
- The CCG and membership understand that whilst not directly commissioning GP services (this is done by NHS England) it has a key role in supporting NHS England to improve the quality of primary care, and has been leading this agenda locally for sometime
- The current pressures on primary are increasing because of recent changes and this makes transforming primary care both imperative but also even more challenging
- We have a history of financial stability, but the current challenges are unprecedented and we can only meet this challenge by delivering this transformational change.

3. How will we deliver this

- In collaboration with NHS England we will deliver our primary care objectives, ensuring fairness, equity and transparency in the decisions we make - especially given potential conflicts on interest of GPs as both commissioners and providers
- We aim to improve the productivity and sustainability of all health services with a strategic shift of activity from hospitals to the community by providing care closer to people's homes, ensuring people do not spend any longer in hospital than they need to and preventing the need for hospital admission wherever possible. This will mean fewer people will need to attend the Emergency Department (ED) and have unplanned admissions to hospital
- We will improve communication across NHS and social care providers by integrating services to reduce duplication and errors and make care more holistic
- We will promote the right culture that places the patient at the heart of everything we do, and which encourages innovation and transformation

4. What are the benefits of this vision for Primary care?

The Primary Care vision offers general practices, the opportunity to work more closely and collaboratively, by doing so they improve efficiencies and capacities to:

- Improve access and quality through shared resources and support
- Strengthen the capacity of primary care to enable care to be seen closer to home
- Share corporate and financial services such as shared tendering, Human Resources, accounts and other back office functionality
- Share clinical support or general mentor support to enable increase resources and shared care.
- Improve local service integration across practices and other providers
- Improve quality and safety of services
- Develop training and education capacity
- Reduce un-necessary hospital admissions.
- Maximise income to be reinvested into patient care
-

5. What are the benefits of the Primary Care vision for patients and families?

The Primary Care Vision will improve quality and inefficiencies for the patients and families by:

- Having improved and sustainable access to primary care services
- Providing a more holistic approach to meeting individual patient needs, rather than the patient being seen by a multitude of separate independent health and social care workers, they will be seen by a member of the neighbourhood team who will coordinate appropriate input from other team members
- Ensuring better continuity of care for patients is improved through the multi-disciplinary team meetings as more team members will be familiar with the patient
- Providing links for patients and carers to other agencies within the community
- The introduction of the multi-disciplinary approach which will allow patients with Long term conditions (LTC) to be better managed in the community and potentially reduce unnecessary hospital admissions or facilitate earlier discharge
- Reducing the likelihood of clinical management errors/misunderstanding
- Improved and equitable access to care.

2. Context

Nottingham City has a very diverse population with different needs who require a wide range of services from primary care providers. There is also a significant amount of variation in the provision both in size and quality of service provision. Our clusters are seeing a higher than expected use of costly hospital services. Some of the services have potential to be more appropriately provided in a primary care setting. Better primary care provision will contribute to addressing the life expectancy across the city.

Primary care is key to delivering a cost-effective health care system for our population. Primary care is the first point of contact for more than 90% of our patients and service-users in accessing care. Primary Healthcare teams play a crucial role in chronic disease management, health promotion, diagnostics and early intervention, and treatment information management.

Through clinical commissioning, GPs have a shared financial responsibility hold for many local NHS services however this also puts them in a potential position of conflict as local independent providers. In developing our primary care objectives, we recognised this conflict and looked at what primary care should look like from the eyes of our patients (see patient vision later in the document). In doing this, we are able to transparently develop a vision and objectives strategy that meets the needs of our patient population.

We have, through Practice Based Commissioning (PBC) and the early years of clinical commissioning, seen good examples of quality and innovation across Nottingham City. The hard work and dedication of staff across general practice has delivered real improvements for patients. However, we still have variation in the clinical quality of general practice provision with differential health outcomes for residents across the City.

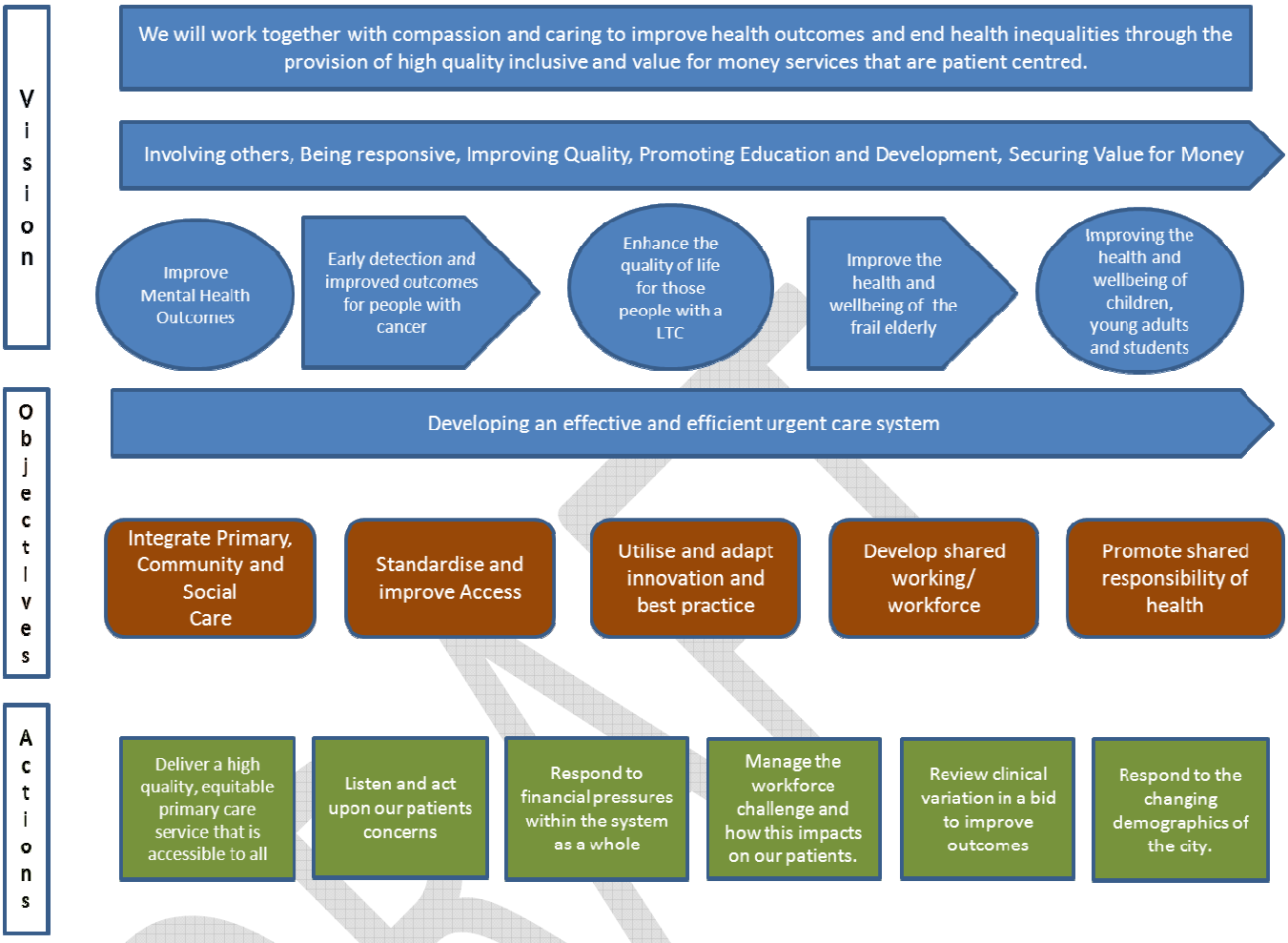
Our case for change focuses on the following factors:

- Rapidly changing population
- High levels of health and wellbeing need
- Variations in access to primary care medical services
- Variations in clinical quality and patient health outcomes
- Variations in the premises from which primary health care is delivered
- A changing workforce profile and changing skills set needed for new models of care
- A shift towards moving follow-up and care into the community.

The NHS has to reduce the cost of health care and improve the efficiency of service providers and the health outcomes for local populations. GPs have taken a central role in health care planning and primary care will be commissioned by the NHS England. The intention of this plan is to identify the areas of change and improvement required to transform primary care services to meet the standards that our patients expect. Our aim is to offers general practices, the opportunity to work more closely and collaboratively. In working in an integrated way health and social care services are able to improve efficiency, add capacity and deliver quality through a strengthened and shared workforce, underpinned by training, support and mentorship that are tailored to the populations need with the aim of delivering care closer to home. This redesign will improve and extend access to primary and community services while reducing hospital admissions and length of stay.

3. What is the Primary Vision?

(plan on a page)



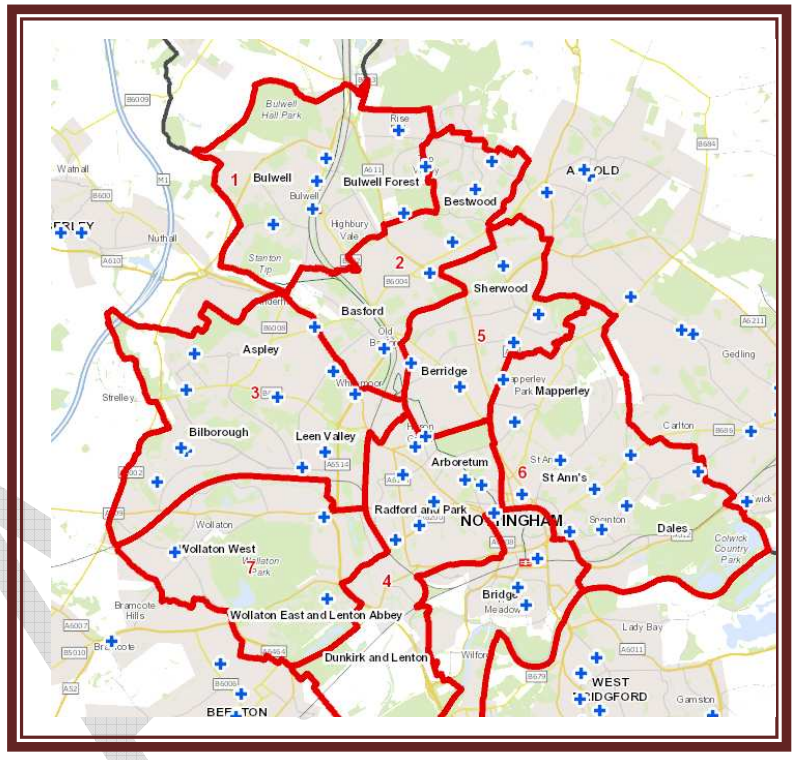
Currently all Nottingham City GP Practices are aligned via commissioning clusters. These clusters enable 'like minded' GPs to come together to commission services for their population. These commissioning structures have been extremely successful for Nottingham City, and will remain. Therefore in order to improve quality within Primary Care we will focus on the following objectives:-

1. Integrate Primary Community and social care
2. Develop shared workforce/working
3. Standardise and improve access
4. Utilise and adapt innovative technology and best practice
5. Promote shared responsibility of health
6. Utilise resources and funds available within the Challenge Fund

4. How will we deliver the Primary Vision?

4.1. Integrate Primary Community and social care

There is a strong national driver to improve services through better integration. Integrated care is seen as being essential to meeting the needs of an ageing population, transform the way that care is provided for people with long term conditions and enable people with complex needs to live healthy, fulfilling independent lives.

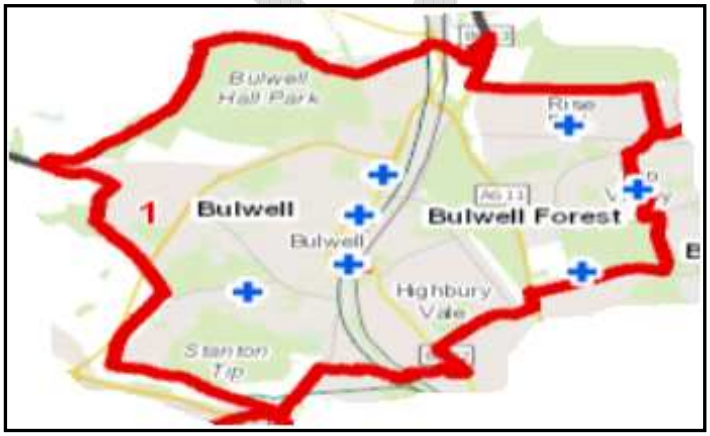


Nottingham City's Adult Integrated Care Programme was established in July 2012. A partnership between NHS Nottingham City CCG and Nottingham City Council has been created in order to develop an integrated health and social care system that focusses on patients with long term conditions as well as the frail elderly. The intention of the programme is to design a system of care that is less fragmented and in turn improve patient outcomes and help drive efficiencies across health and social care.

Nottingham City CCG will as part of its integrated care project, align practices and wrapping community provision within each care delivery group. These care delivery groups will enable providers to utilise and share resources for patients within a similar demographic area. Working with the Local Authority we have been able to mirror social care provision, moving towards all teams becoming integrated and tailored to a particular demographic need, whilst working together to utilise and share a limited workforce.

4.2. Develop shared workforce/working

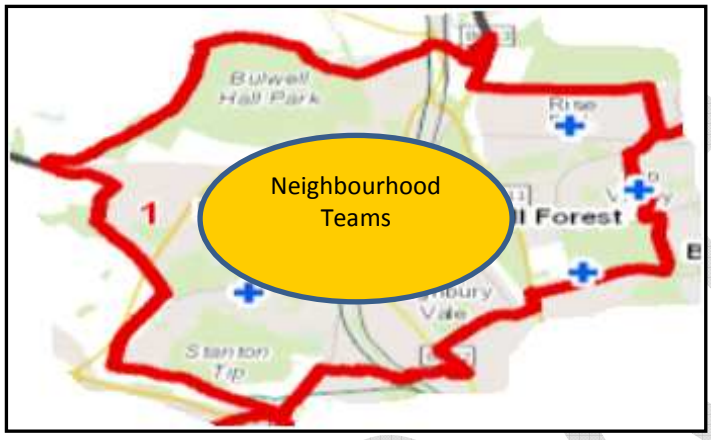
Traditionally, workforce planning has been about ensuring that we are able to maintain the supply of nurses, doctors, and AHPs to meet demand. However, changing population demographics, service delivery imperatives and future workforce profiles and the subsequent change in the needs of patients, means the need to support appropriate care models for role flexibility becomes ever greater. It will be important for the CCG to modernise and further develop its models of delivery and community nursing services and allied health profession services by reconfiguring the existing workforce and introducing a new mix of skills and competencies to meet these challenges. Feedback from GP practices, community providers and local authority provision has highlighted that all providers are facing a number of similar challenges. These challenges such as; variations in provision, limitations and



reduction in the workforce, reduction in funds and an increase in demand has resulted in Nottingham City changing the way services are currently delivering care.

GP Alliances/Federations - Once aligned within a care delivery group, It is anticipated that some GP practices will collaborate in a federation/GP community. These alliances (dependent on form and function) will be underpinned by robust and strong governance arrangements. All alliances will retain the benefits of the local GP practice but strengthen the capacity of the practice by having access to a shared workforce, enabling patients to have greater and improved access to primary care services. In an environment where resources and funds are becoming limited, federations will enable practices to make efficiency savings/economies of scale in back office functions, developing training and education capacity and deliver provision on behalf of its locality. These federations or alliances will also have the opportunity of sharing or employing a clinical workforce on behalf of its locality.

Neighbourhood Teams - Neighbourhood Teams will be populated on the needs of that locality based on identified need and requirements from the joint strategic needs assessment and primary care feedback. Core teams will consist of Community matrons, community nurses, occupational therapists, physiotherapists, social workers, and support workers. The teams will be tailored and wrapped around the Care delivery group, accessed via a Care co-ordinator, who's responsibility and remit will be to guide patients and primary care through a complex system, ensuring patients and clinicians are seen once by an integrated service, rather than multiple times from multiple organisations.



4.3 Standardise and improve access

Access to primary medical services is a key consideration in improving the delivery of services and ensuring patients are at the heart of how these are designed and provided. The national survey results as part of the Better Together patient experience programme give a picture of patients' perception of access. It will be crucial to use these results to focus actions and give priority to helping all Primary Care contractors improve access for patients. A recent patient survey of over 700 patients within Nottingham City highlighted that access for GP appointments should be at one day of an urgent appointment, and 3 days for a routine appointment. With the aim of improving access and quality in Nottingham city practices we will work with GP surgeries to deliver the following standards:-

- *GP Triage* - Where willing, we will encourage practices to review their booking systems and appointment allocation. Due to the increased numbers of appointments needed and the reduction in workforce, the CCG will encourage practices to review the system in which clinical appointment triage is carried out prior to an appointment being offered. This system tried and tested in other areas, enables those patients who are more needy to have quicker access to a primary care clinician, by capacity being freed up by utilising a telephone and virtual triage approach.

- *Standard access* - Practices will demonstrate 95% achievement of the urgent access standards. These being that patients are seen within the same day of their condition being diagnosed as urgent by an appropriate clinician. Practices will demonstrate an average of 90% achievement of the routine access standards. These being that patients are seen within 3 days of request for a routine GP appointment.

- *Online Booking* - Promote and advertise online access to appointments. Within the GP contract practices must ensure electronic access to appointments is available. The CCG will support practices to ensure a consistent approach to the marketing and management of these appointments is given to its patient population. This will include more technical support to ensure mobile phone appointment bookings, reminders and cancellations are also utilised.

- *7 Day Working* - Working in partnership with NHS England, the CCG will look to commission a service in which each care delivery group will make a number of routine appointments available on a Saturday and/or Sunday. Access to these appointments are co-ordinated by the care delivery group and based on need (i.e. those patients unable to attend the practice during a weekday). These weekend clinics supported by the necessary admin functions and Practice Nurse will aim to be delivered within the same building as neighbourhood teams, enabling access and links with community provision whilst managing and maintaining estate costs. The patient survey recognised that while these appointments were necessary, it was accepted that accessing appointments at weekends would result in the patient losing the ability to choose which GP they prefer to see. The extended hours GP will be responsible for liaising with the practice regarding treatment and outcomes in a similar style to that provided by the Out of Hours service (Nottingham Emergency Medical Services).

- *Training for frontline staff* - The medical receptionist is a central function to the GP practice. Over the years the perception gained by patients is that the receptionist is the 'gate keeper' to the GPs time. This has been substantiated within a local survey carried out by Nottingham City CCG. In order to progress with improving access to primary care we feel it is necessary to dispel this common misrepresentation. With intensive training, development and supported by a marketing strategy our aims is to ensure all receptionists and frontline staff within practices attend an intensive training course in which they will be developed into healthcare guides. Receptionists will be trained on how the healthcare system works, the importance they plan within this role and how they can steer, guide and support patients through a complex, confusing and sometimes frustrating situation. This training package will be bespoke to Nottingham City, with all practices sending their receptionists to at least 1 out of the 4 available courses.

- *Home Visiting Services* - The Home Visiting Service will support GP practices by providing a rapid access service for acute care at home, thus reducing the need to access urgent hospital care. The service aims to streamline emergency admissions and attendance by better managed access, utilise existing commissioned services and achieve better patient satisfaction. The Home Visiting Service will be available between 9:00 am and 1.00 pm Monday to Friday. The clinicians who make the visits are all local therefore familiar with local services and care pathways and aim to visit the patients within 60 minutes with a basic clinical history provided by the patients GP. This will include: Direct access telephone number for practice with named contact in case of queries, presenting complaint, relevant history and repeat medication list. Where a GP attendance is required the GP will have the technology and facilities to carry out a full appraisal within the patients home (mobile technology), including electronic access to notes and the documentation of vital information.

- *Enhanced Services* - The CCG will review and realign Local Enhanced Services (now known as Primary Care Contracts). The CCG will aim to ensure that they are fit for purpose and commissioned in a transparent, simple way as possible. We will do this through continued engagement with all interested parties so that by Spring 2014 we will be in a position to ensure all patients have more local access and choice to primary care services such as wound care and phlebotomy.

- *Pathways website* - Agreed care pathways assist both healthcare staff and patients understand and achieve the best approaches for care which is safe, person centred and clinically and cost effective. It is recognised that the combination of targeted action within Primary Care, and both informing and empowering the individual with a condition, will improve their sense of wellbeing and avoid repeated admission to hospital. In the first instance, we will focus on pathways where the behaviour of Primary Care has the greatest impact on Secondary Care and on the health service as a whole. However we will also work with key stakeholders to ensure that boundaries, and organisations do not fragment the information to needed by our patient population.

- *Responsiveness contract* - The CCG will develop a one year "Responsiveness contract" that will incentivise practices to adopt and migrate to the change programmes listed within this document. The incentive payment will be underpinned with key requirements that will enable practices to use the funds for back-fill, engagement and training in order to make the leap to a new way of working. While it is recognised that the change proposed within the document will benefit patients, the pace of change will be dependent on practices ability to adopt.

4.4 Utilise and adapt innovative technology and best practice

Nottingham City CCG recognises that the GP clinical system is a strategic component within healthcare. The quality of clinical data held within GP systems has never been more important both internally to support the clinical and business processes within GP practices, and externally to support the delivery of care in the wider context. Advances in technology such as skype, online bookings, electronic prescribing, shared data and tele-health, tele-care and tele-medicine are ever more important in managing the health of our population. The success of this vision, is dependent on a robust and sustainable IT infrastructure, therefore it is essential that this vision is read alongside the CCGs Information Technology plan 2013/2016 and the Adult Integrated Care Assistive Technology strategy.

4.5 Promote shared responsibility of health

It is essential that patients feel empowered to manage their own health and social care needs and have the necessary information at hand to do this. We will ensure that where possible, and safe to do so, we will commission and encourage direct access services to support our patients to directly refer for routing car such as physiotherapy and podiatry services. We will also ensure that all practices contain information on how patients are able to direct themselves to and around the complexities within health and social care with support from the practice receptionist (see practice receptionist training). The CCG is working with the local Authority to ensure a collaborative approach to self care. Each practice will have a self referral information that will guide patients on how to:-

- Find information on their condition
- Access self help treatments and services
- Order equipment
- Find people with a similar condition to talk to
- Make lifestyle changes eg: losing weight, being more active or stopping smoking
- Get help for carers
- Create their own care plans

5. What will this mean to our patients?

Taking into account national policy and guidance on how primary care should be developed, we need to be aspirational and ambitious in our future planning and delivery of primary care services. Therefore, building on the national document *The Patients' Voice* and more recently using information obtained from *"A Call to Action"* and "*Improving primary care – a call to action" as well as* the Royal College of General Practitioners *"General Practice 2022* we will use the information we know about our population and the national direction of travel, to steer a vision for primary care in Nottingham City:

Our buildings

In 2016 all our practices are Care Quality Commission (CQC) registered, with their premises being fit for purpose irrespective of the age and type of building. We have a mix of new and old, large and small buildings; but they are all clean, bright, and tidy and will display only current relevant information about our services.

Primary care buildings are supported by NHS England and we will work with our practices and NHS England to ensure that our buildings are accessible for all, including the disabled, and will conform to all health and safety and infection control requirements, ensuring a safe and clean environment. There will be a comfortable waiting area and all of our practices are child friendly, understanding the needs of both parents and children, at what may be a stressful time.

Accessing the practice

On arrival, the practice reception staff will be welcoming and patients will be able to check-in confidentially, either face to face, or electronically. New patients will be introduced to the "primary care information pack" that will guide patients through the things that will be useful including:

- How to get a personal health profile
- Self-care and lifestyle advice
- Exercise and diet on prescription
- Housing, benefits, employment, healthy foods and cookery advice
- Specialist advice on drugs and alcohol abuse
- Specialist advice and support for sexual health services.
- Details of how to access all services.

The primary care information pack will view patients as a member of the local health community and will provide them with public health information about disease patterns, likelihood and symptoms. We know the expected patterns of ill-health in a community and can advise patients on healthy living, prevention and early diagnosis. Health promotion and illness prevention is as much a part of our service as care and treatment.

For routine (non-emergency) issues, patients will have access to their practice via phone or in person weekdays between 8am and 6.30pm with appointment available at the weekend and evenings for those individuals or are unable to access weekday appointments. Maximum waits for routine appointments will be 3 days however we recognise that clinical need will determine how quickly a patient requires an appointments. Service provision will be communicated via NHS Choices and the practices own website. Occasionally, a practice may close for a half-day staff training session, but they will have arranged for an out of hours care provider to cover any patient needs.

On the day that a patient makes an appointment the reception staff will courteously and professionally try to direct the patient to the most appropriate clinician. This may include offering

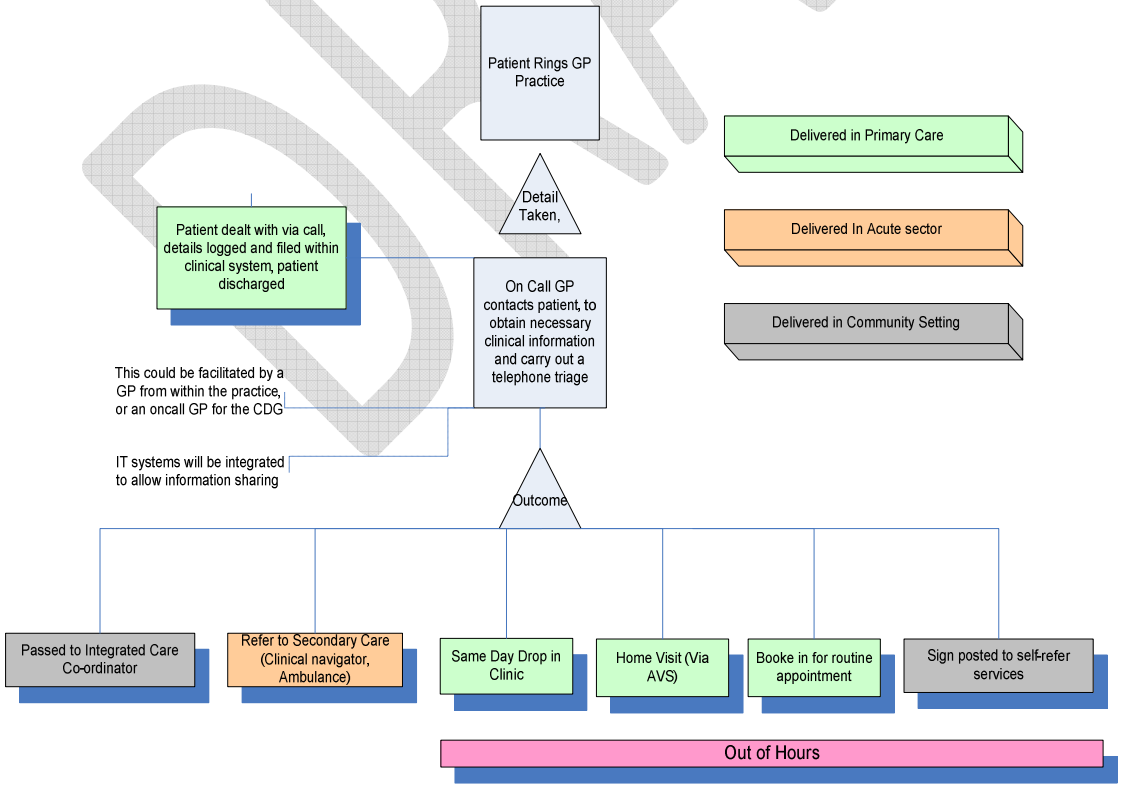
the patient a face to face, telephone, Skype or email consultation. This is not a triage process; merely trying to quickly guide the patient to the most appropriate team enabling the patient to be seen quicker and again flexing the capacity of our integrated teams. If continuity of care is important the practice will respect this, and where practical and safe to do so offer an appointment with the clinician of your choice.

GPs will be able to offer patients a consultation locally, often with a specialist community-based service, or will arrange a hospital appointment. Our coordinated care pathways will mean that GPs, the community services and the hospital consultants can communicate electronically to share information and agree on the best course of action to meet patients' particular needs. All clinicians will actively involve patients and their carers' in decisions about their care and treatment. Our GPs will only ever do what they know they can do safely in their own practice, and sometimes it will be necessary to refer a patient for further diagnostic tests and/or treatment.

<u>What if a patient needs urgent access?</u>

The practice will have set up a responsive urgent system which will include discussion with a clinician who will triage the patient's symptoms and discuss the most appropriate route for the patient. If an appointment is needed whether in the practice or at home, the 'on call' Primary care team will ensure that the patient is seen and treated the same day within the most appropriate setting. This may look like a drop-in urgent care clinic. If a home visit is required, the 'on call' service will liaise with the home visiting service and arrange for an experienced clinician to visit the patient in their home. During this urgent need the practice cannot guarantee that the patient will be seen by their own GP, however the practice will ensure that the patient is seen in a timely manner, with the visiting clinician having full access to the patients clinical records.

<u>What Does Access into Primary Care look like for our Patients?</u>



How will these networks communicate with one another?

Communication between practices will mostly be electronic as most practices use the same computer system, but those few who have a different system can still communicate with each other across the IT network. With a patients' permission practices will also be able to communicate directly with other community-based clinicians and hospitals to ensure effective transfer of relevant patient information across organisational boundaries.

In line with national policy, patients will be able to log on to the same system to check their own health summary care record at any time. If a patient doesn't have a computer or smart phone available they will be able to use the surgery patient computer to check their records, make future appointments or re-order medication.

How will long term conditions be managed in primary care?

Our aim is to free up the GP time to enable them to focus more on managing those patients with a Long Term Condition (LTC). The GP will work with the patient to ensure a proactive approach to the management of the patient's condition, particularly as long-term conditions such as chronic obstructive pulmonary disease (COPD) and diabetes will require monitoring and treatment over a long period of time. Consistency and support is key, therefore the GP will aim to diagnose a condition early to enable treatment to start as soon as possible and ensure that care is available seven days a week.

When a patient is first diagnosed with a long-term condition practices will:

- Provide them with full educational information about their condition soon after diagnosis
- Introduce the patient to the relevant nursing team who will lead much of their long-term conditions management
- Advise patients of additional support services. These will often be patient groups or charities that are expert in the management a patient's condition but may include those available through pharmacies.
- Agree a package of care based on need. This will include a written Care Plan with mutually agreed goals and periodic and annual reviews.
- Agree with the patient what supported self-care they can do for themselves and when to seek the help of their healthcare team.

We want patients to become confident in managing their own condition as much as possible. If a patient has a complex condition, or set of conditions, we will ensure they are appointed with a named care co-ordinator, to work with them and the rest of the team. They will then help patients to implement their Care Plan; we will ensure they have one integrated plan, not many disconnected ones.

What if a patient needs an operation?

We will do as much as we can to avoid unnecessary hospital admissions, including giving patients access to information to enable them to make an informed decision about whether or not an operation is the right procedure for them, and which provider and specialist to see. If however, following a consultation with the GP, a patient decides that an operation is necessary, their GP will:

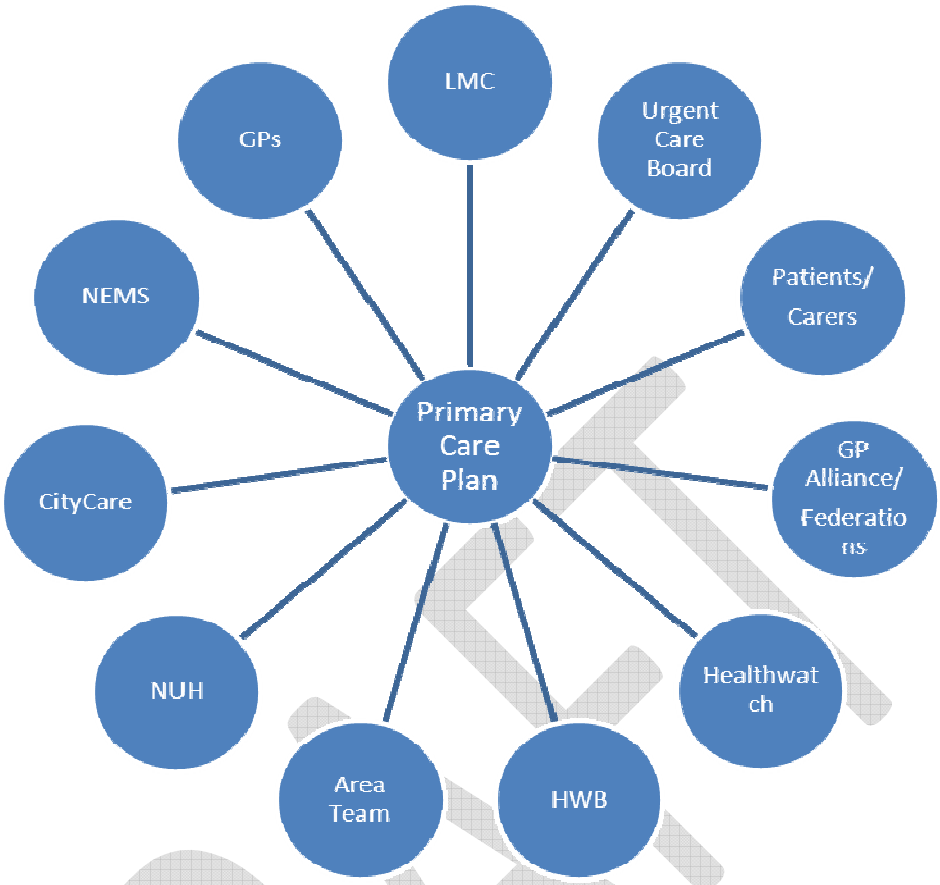
- Offer a choice of hospital and consultant
- Use the Choose and Book system to refer the patient to the appropriate specialty
- Have access to information to confirm that the hospital makes all parties aware of the discharge arrangements and discharge plan details

- Support a patients rehabilitation and convalescence at home or in a community setting
- Work with the hospital to arrange any follow up consultations with the most appropriate clinician, who may be the GP, the hospital consultant or another specialist clinician. These maybe face to face but equally where appropriate may involve telephone or email reviews.

How will primary care keep up to date with latest practices and innovation?

We will ensure we are fully linked with the latest developments within NICE and other health organisations. Our clusters will encourage innovation in which primary, community and secondary care providers will develop localised pathways that meet the needs of its population while taking into consideration innovation. We will support training and learning through our Protected Learning Times (PLT), and the Academic Health Science Network (AHSN) and wherever possible continue to support research within our practices, in a bid to further develop knowledge and outcomes that will benefit the wider population.

2. Stakeholder Engagement



It is important that our stakeholders are included within this plan. As an integral part of the primary care infrastructure we want them as enablers of this vision to have a clear understanding for our case for change. Excellent communication and engagement will ensure our stakeholders are able to deliver our primary care plan and also enable them to be clear about how their roles contribute to us achieving this our innovative change in direction.

The main aim of communication and engagement within this plan is to communicate our vision and deliver our priorities. We have identified the following communication and engagement vision statements which will help us to do this:

- Ensure stakeholders are fully engaged and are able to feed into the development process
- Proactively build continuous, meaningful engagement with the public and patients to shape services and improve health.
- To ensure that everybody who wants to influence the planning, development, review and improvement of services has the opportunity to do so.

3. Key Performance Indicators (still under development – PH are advising we look at four main areas and these then are sub categories, the four areas would be LTC/Complex; Frail elderly; Prevalence; Risk factors

*specific KPIs to be agreed locally

Key Performance Indicator	Measure/Indicator
1. Satisfied patients	a. Evaluation of the pilot using qualitative and quantitative design utilising patient participation groups – using quality of life measures adapted from PROMs
	b. Number of complaints received about the service each month
	c. Number of incidents
	d. Proportion of patient reporting easier, on-line registration
	e. Number of patients requiring referral back to the GP following redirection to alternative service
	f. Number of patients offered a choice of primary care services within AQP process
	g. Number of patient accessing electronic prescriptions and online booking of appointments
	h. GP survey to measure satisfaction to include experience of the practice offer, attitudes, cleanliness and CQC registration
2. Motivated positive staff	a. Staff questionnaire – to include experience and level of skill
	b. Training and development
	c. Number of WTE staff working in the service
	d. GP and practice staff evaluation
	e. Proportion of time GP and practice staff for multi-disciplinary working with the wider health and social care team across all sectors including children's and adults public health services
3. Outcomes	a. Proportion of patients with long term conditions/complex needs which are case managed increase from baseline
	b. Proportion of patients with end of life needs actively case managed from baseline
	c. Proportion of residential and nursing home patients case managed increase from baseline
	d. Proportion of readmissions within 30 days
	e. Proportion of expedited discharges
	f. Proportion of patient entering long term care
	g. Proportion of patients living at home
	h. Proportion of health checks completed
	i. Patient not accessing the services but with inequalities or life style issues identified and actively managed
	j. Proportion of patients on long term sickness notifications
	k. Number of emergency department attendances/non-elective admissions and mental health admissions
	l. Length of stay in hospital
	m. Proportion of use of ambulance and transport services

4. Financial management	a) Cost effectiveness (avoidance, reduction and savings) due to the pilot

4. Enablers to deliver the vision

To deliver the CCGs vision, we will need key partners and stakeholders to be fully informed, engaged and supportive of this vision. This will include developing a sustainable highly motivated workforce, estate capacity to meet the needs of care closer to home while ensuring equity of funding.

In terms of specific requirements the following actions will be undertaken:

Vision/Outcome	Delivery Mechanism	Resource
Distribution of primary care welcome packs to all new patients, informing of all services and care available from a health and social care setting and how to access it	Health care info and map, PH info, How to use ED, how to access the practice, who to call in an emergency. Opening and closing hours	Practice, CCG, LA, LAT, NUH, CityCare, NHT, NCVS
Improved and convenient options of making, cancelling or re-arranging an appointment	Improved IT and technology such as practice apps, appointments, email addresses and text reminders	Practice, NHIS, Practice, CCG
Improved information, communication and support to enable and encourage self-care/management	Practice/patient computer, practice App, practice email address, E-prescribing, National Summary Health record, expert patient, remote monitoring	Practice, NHSCB, CCG, independent, carers groups
Technology and infrastructure available and ready to support integrated and aligned working arrangements.	Integrated systems Shared access to appointment bookings and records	Practice, NHSHIS, LA, CCG
Develop a culture that is patient focussed. Ensure those who work in primary care are appropriately skilled, supported, educated and informed to deliver optimum care in their role	Practice visits, peer support, mentoring, pathway launches and development, personal development plans, appraisals, 1-2-1s, customer service courses, revalidation, PLTs	CCG, AT, LETB, independent courses, recruitment
Clear and Non Jargon communication from your clinician when an operation is required, including support to enable patients to decide the appropriate treatment for them	Expert patient programme	CCG, LETB, patient
Supported discharges with a full and co-ordinated care plan between primary, secondary and community care with access to a specialist within the community	Follow up and discharge activity plans.	Practice, NUH, CityCare, CCG, patient
Ensure choice is offered, supporting patients to choose the most convenient date, location, provider and consultant for his/her condition	Choose and Book, NHS Choices, CAS	CCG, Choice Website, National Choose and Book Team.
Develop a culture where innovation is used to develop new and improved services for patient population, using national guidance and local patient input	Under-spends, innovation funds, national funds, non- recurrent sums, feedback forms.	Practice, CCG, LAT, national institute for innovation, patient AHSN, Public Health
Ensure patients have the opportunity within the practice to make recommendations for commissioning improvement or raise concerns regarding existing	Practice participation group, feedback forms, genera patient feedback email address, text, twitter, patient council, patient representative on cluster board,	

clinical care	pathway redesign input	
Safe clean and fit for purpose premises that are easily accessible to all patients, located in areas of need	CQC registration, Primary Care accommodation review, patient feedback	PropCo, CCG LAT, LMC
Development of natural GP communities working within federations to enable practices to partner up to deliver all or part of clinical services supported by a central back office function	Primary Care alliance, federations, Natural GP Communities	Practice, CCG, LAT, LMC
Practices working within natural communities to meet the demands of 7 day working, ensuring practices and services are more geographically accessible	Primary Care alliances, contracts, home visiting service, natural GP communities	Practice, CCG, LAT, LMC
Commission and support GP First, enabling urgent access to be screened and dealt with according to need by an appropriate professional	Primary care alliances, contracts.	Practice, CCG, LAT, LMC
Out of hours provision offering equitable and consistent clinical care	111, GP out of hours, Clinical Navigator, crisis team	CCG, eHealthscope, LETB, LAT, Institute for innovation, NVQ
Ensure each Care Delivery Group has access to, and clear guidance on how to access the home visiting service, 7 days a week.	Primary Care alliance, CCG commissioning.	Practice, CCG, LAT, LMC
Strategic workforce review and plan ensuring consistency and care in future years	Workforce strategy review, horizon scanning	Practice, CCG, LETB, LAT
Integration across primary and community care, within health and social care	Integrated workplan	Practice, CCG, LETB, LAT
Greater access to primary care provision through shared resources and teams	AQP, LA, community contracts, GP Federations, Alliances	Practice, CCG, LA, NHSCB, CityCare, patient
Reduced variation in primary care through ongoing monitoring and support	QIC, primary care steering group, practice visits programme, QoF, practice quality reports, eHealthscope	Practice, CCG, LAT, LMC patient

5. How will we know if we are doing a good job?

We will know we are doing a good job when we have the right people being cared for in the most appropriate setting demonstrated by progress against trajectories. Feedback and ensuring consistent high quality is paramount. The following will assist us in gauging our success:-

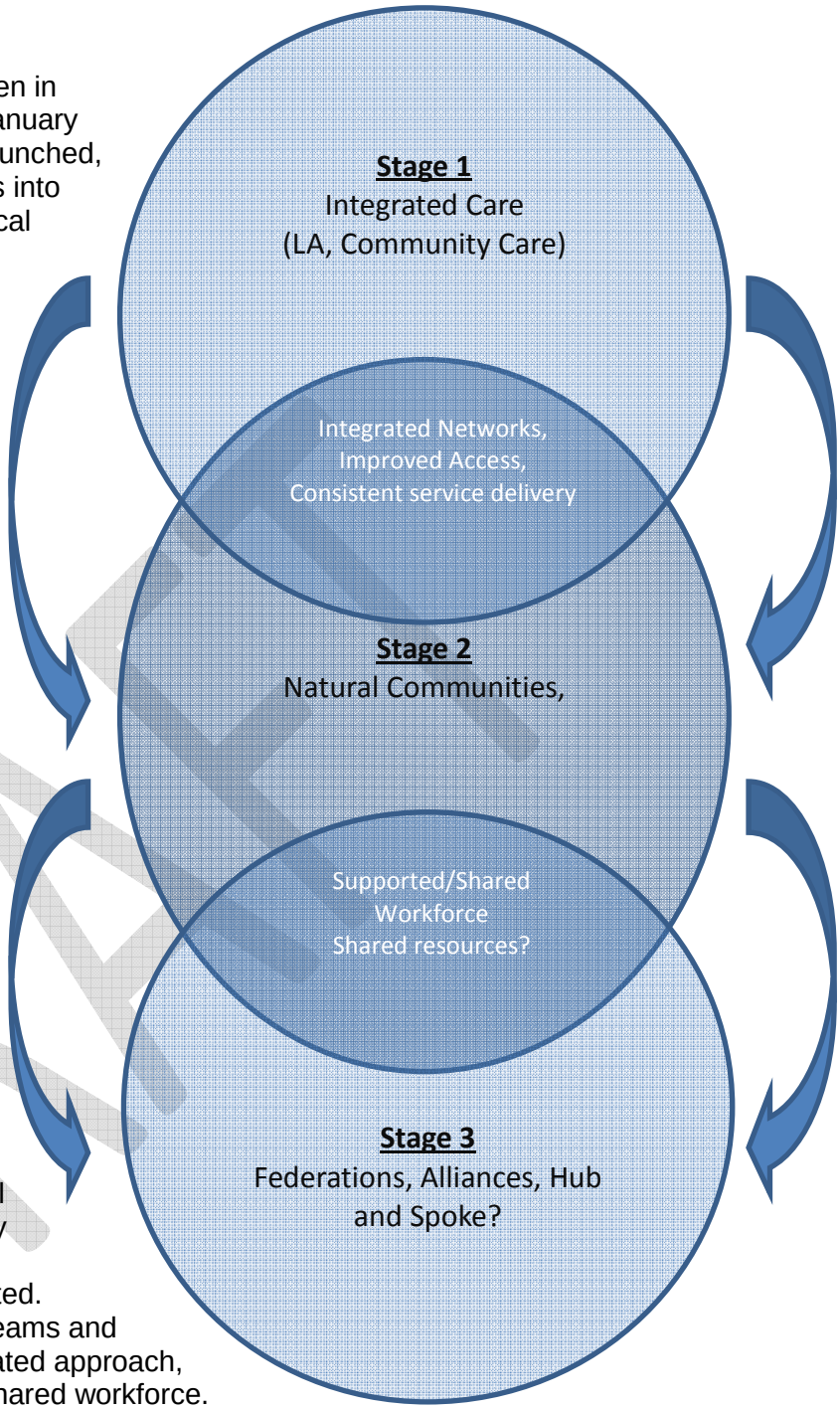
- We will work with NHS England to monitor the quality of primary care through their web based tool, alongside our local system called eHealthScope benchmarking performance against all practices within Nottingham City to ensure our service is at a consistent level and a standard.
- We will participate in an annual peer-to-peer review, with practices agreeing and implementing specific actions that will improve and enhance the quality of service to patients. This data and actions will be compared year on year to ensure that primary care services are improving, and service delivery is meeting the needs of our patients.
- Our practices will actively seek and welcome feedback from patients on their experience of services including the use of the friends and family test.
- The practice and CCG will monitor complaints as an opportunity to improve services and the practice will acknowledge a patients complaint within 48 hours and keep them advised of progress.
- We will undertake regular patient surveys and the results and will publish this information. This will augmented by mystery shopper assessments from which practices will be required to develop action plans to address any areas where potential improvements have been identified.
- We will routinely assess our services against the needs of our diverse population to ensure that they offer equality to the rich diversity of City residents.
- We will engage in more formal public involvement through local networks and independent consumer organisations that will have the statutory right of entry to visit the premises of service providers and to report their findings.

6. When will this change happen?

Stage 1 - January 2014 - April 2014
The Integrated care programme has been in operation for a number of months. In January 2014, the care delivery groups will be launched, bringing together services and providers into network locations that are aligned to Local Authority provision. During this time a project manager will facilitate bringing the practices together to meet the neighbourhood teams.

Stage 2 – From April 2014 to March 2018, GPs will be supported to develop natural GP communities to enable them to share their resources. As part of these 'natural communities" practices will come together and identify a common purpose in which working in partnership would benefit them. This may include integrating/supporting back office functions, sharing clinical support or general mentor support. During this phase, the practices will be introduced to GP first, and the home visiting service.

Stage 3 – From January 2014 - March 2018 the "natural GP communities" will formalise their alliance through a robust arrangement that enables them to work as a community network of GPs enabling their patients to have greater access to a shared clinical team that will be responsible for delivering high quality care in a time when resources and funds are limited. During this phase, the neighbourhood teams and providers will begin to work in an integrated approach, including multi-disciplinary teams and shared workforce.



7. Evaluation

We will work with NHS England who have commissioned the Collaboration for Leadership in Applied Health Research and Care (CLAHRC) to evaluate our plan to ensure the outcomes and KPIs are either met, or lessons learned are shared. This evaluation will enable the CCG to determine the true outcome of this innovative approach to primary care redesign.

2. Appendix 1 - Case for Change

Setting the scene of Primary Care in Nottingham City

Nottingham City Clinical Commissioning Group has 62 practices, with a combined patient population of 340,000. The patient list within the practices varies from 1600 to 36000 dependent on the practice size and location.

Three types of contracts have been available to commission primary medical services:

- General medical services (GMS)
- Personal medical services (PMS) – which includes specialist PMS (SPMS)
- Alternative provider medical services (APMS)

Currently (2013) Nottingham City commissions primary care medical services from 62 independent contractors (down from 63 in 2012). The contracts used vary to meet the needs of our residents, however, all primary medical services contractors (GPs) are required to provide patients with the same essential services. They can opt out of providing additional services, which a few do.

Workforce

The primary care workforce is changing. Retiring GPs, single-handed practices, partnerships dissolving and a national shortage of clinicians will only add to the future challenges within Nottingham City. Our practices are already experiencing difficulties in employing and retaining GP, nurses and workforce to meet the increasing demands on these services. We will proactively identify existing and potential gaps in provision and workforce via direct links with the practice, LMC and Area Teams. These communication links will enable us to triangulate our data, working with stakeholders to plan local and national mitigation plans.

Primary care access arrangements

Primary care access arrangements are referred to in relation to core and extended hours. The GMS Contract defines core hours as the period beginning at 8am and ending at 6.30pm on any day from Monday to Friday, except Good Friday, Christmas Day or bank holidays. The contract states that the contractor must provide essential services (see appendix 1), at such times, within core hours, as are appropriate to meet the reasonable needs of its patients, and to have in place arrangements for patients to access such services.

Practices implement local access arrangements to meet the needs of their patients and their practice. Practices operate systems for walk-in access, same day and pre-booked appointments. Responsibility for triage varies from practice to practice, and between GPs and nurses. Nottingham City has a wide variation in patient access five days a week, with a proportion of practices closing for business one afternoon per week. For practices that are closed one afternoon a week, access to their core services is not available to practice patients but they are able to access urgent care via an out-of-hours provider.

Patient health outcomes

Cancer mortality varies considerably across the City including deaths attributable from tobacco smoking; deaths from cardiovascular disease are higher than expected and we have significant ward-level life expectancy variation between the City and our neighbours.

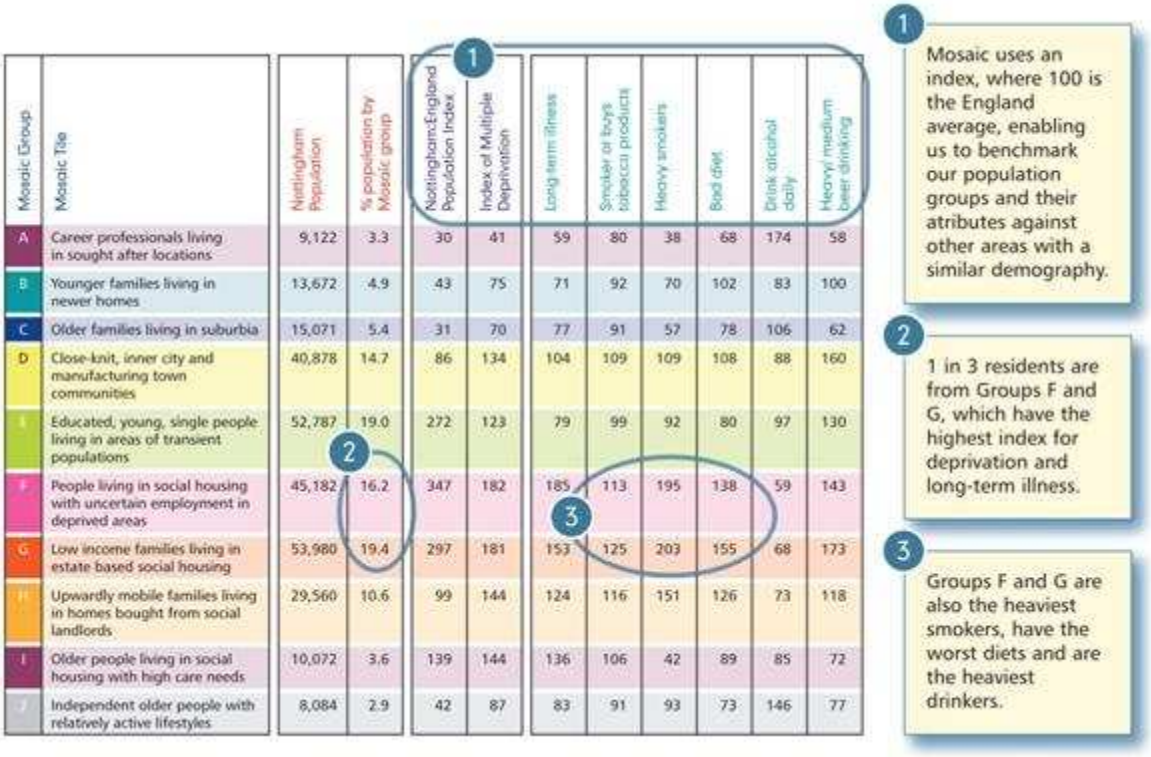
Nottingham City Joint Strategic Needs Assessment (JSNA)

Nottingham City's population increased over the past five years, mainly through migration (recently from Eastern Europe) and an increase in university students, supported by a big increase in house building. The number of births has risen considerably and is likely to continue to rise over the next five years. The proportion of children is lower than average, although much less so for under-fives often because parents and children tend to leave the City before starting school. The City therefore gains young adults due to migration while losing all other age groups.

Nottingham City has a very young population with a high proportion (30%) of people aged 18 to 29, due largely, but not entirely, to the presence of the two universities. Students account for approximately one in nine of the population, however the percentages in other age-groups are commensurately lower than average, with the proportion aged 40 to 69 being particularly low. The trends in the age structure of the City do not follow national trends. In the short to medium term, the City is unlikely to follow the national trend of increasing numbers of people over retirement age.

Analysis shows a higher than average proportion of 'Twilight Subsistence' households in the City. These are characterised as households with older people living in social housing with high care needs and limited access to transportation. One third of City residents aged 60 plus claim Pension Credit, an entitlement intended to raise their income to a minimum level, compared to just over one fifth in Greater Nottingham and England. As depicted in fig 1. Nottingham ranks 13th out of the 354 local authority districts in England for deprivation. The high level of deprivation affects an extensive part of the city, with 56 of the 176 Super Output Areas being within the 10% most deprived in the country, and 106 in the 20% most deprived.

Figure 1



Mosaic Group	Mosaic Tile	Nottingham Population	% population by Mosaic group	Nottingham:England Population Index	Index of Multiple Deprivation	Long-term illness	Smoker or buys tobacco products	Heavy smokers	Bad diet	Drink alcohol daily	Heavy/ medium beer drinking
A	Career professionals living in sought after locations	9,122	3.3	30	41	59	80	38	68	174	58
B	Younger families living in newer homes	13,672	4.9	43	75	71	92	70	102	83	100
C	Older families living in suburbia	15,071	5.4	31	70	77	91	57	78	106	62
D	Close-knit, inner city and manufacturing town communities	40,878	14.7	86	134	104	109	109	108	88	160
E	Educated, young, single people living in areas of transient populations	52,787	19.0	272	123	79	99	92	80	97	130
F	People living in social housing with uncertain employment in deprived areas	45,182	16.2	347	182	185	113	195	138	59	143
G	Low income families living in estate based social housing	53,980	19.4	297	181	153	125	203	155	68	173
H	Upwardly mobile families living in homes bought from social landlords	29,560	10.6	99	144	124	116	151	126	73	118
I	Older people living in social housing with high care needs	10,072	3.6	139	144	136	106	42	89	85	72
J	Independent older people with relatively active lifestyles	8,084	2.9	42	87	83	91	93	73	146	77

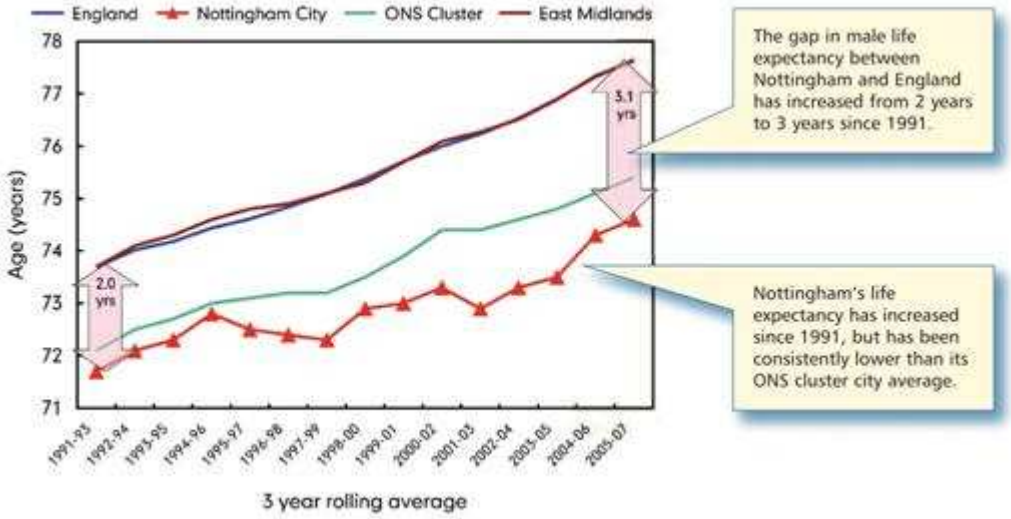
Older peoples' health is generally much worse than that of other groups; nearly half have a limiting long-term illness or disability. Two thirds of clients receiving adult social care support are older people. Most of these require help because of a physical disability (including sensory impairment) or frailty, and one in ten needs support due to mental health problems. The City has

a very high rate of avoidable injury in over 64 year olds. 70% of these injuries are due to falls, which can directly lead to disability or death for older people.

Teenage pregnancy is high in the City compared with the rest of the country at 49.5 conceptions per 1000 girls aged 15-17, compared with 30.7 nationally. Some wards in the City have a rate higher than twice the national average. This overall high rate for the City remains static despite implementation of interventions that have been effective elsewhere. 20% of year 6 age children are classed as obese, and are likely to grow into obese adults at risk of heart disease, stroke and type 2 diabetes.

Nottingham's high levels of deprivation, high level of unemployment, low educational attainment and unhealthy lifestyles (high smoking, poor diet, and low physical activity) are all interrelated determinants of its poor health outcomes and high level of health inequality.

Figure 2



In overall terms the City's residents are less healthy than elsewhere in the country. Life expectancy in Nottingham for men is 75 years, compared with 78 for Greater Nottingham and for England, and for women 80 years compared with 82 for Greater Nottingham and England . The gap in life expectancy between Nottingham and England has been widening since the early 1990s (Figure 2). Within the City there are high levels of health inequalities – life expectancy varies by ten years between the most and least deprived wards of St Ann's and Wollaton West. 15 of the 20 wards have significantly lower life expectancy than the regional average. The most significant disease contributors to our lower than average life expectancy are premature deaths caused by cardiovascular disease (CVD), respiratory diseases and cancers.

<u>Clinical variations</u>

Nottingham City has areas of excellence in the provision of primary medical services, but we also have other areas where the quality falls below expected standards, these are monitored through Quality Outcomes Framework or other national performance dashboards. There are many examples where we know that if primary care providers improved their range of services and clinical quality performance, this would have a positive impact on a range of health issues for the residents of Nottingham City.

Variation in quality and outcomes framework performance

The quality and outcomes framework (QOF) is a national annual incentive scheme for general practices which rewards them for improving the quality of their clinical services and the way they are provided. Practices are rewarded for their performance in a number of areas, but in particular for improvements they make in the management of patients with long term conditions.

As this is a national scheme, we can compare the performance of practices in Nottingham City against each other as well as against the performance of others in England. Data from QOF is an important measure of the performance of GP practices and CCGs in how well, for example, long-term conditions are managed. It is possible to compare the recorded prevalence of the long-term conditions in the registered population with the expected prevalence. This can indicate unmet health need in the population. QOF allows practices to exception-report (exclude) specific patients from data collected to calculate achievement scores.

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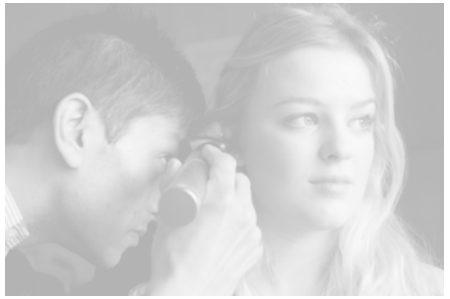
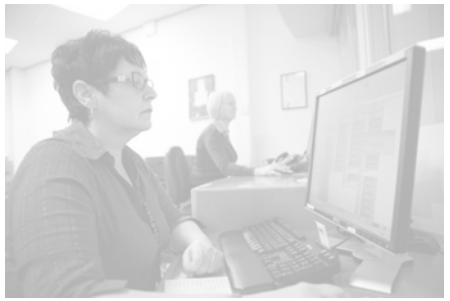
Primary Care Plan

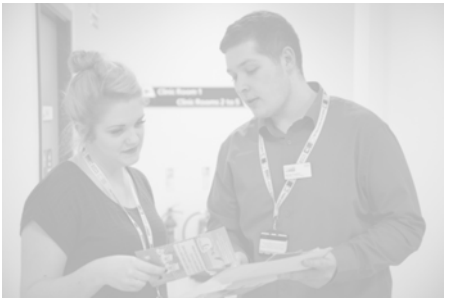
Maria Principe

Director of Primary Care Development and Service Integration

February 2014







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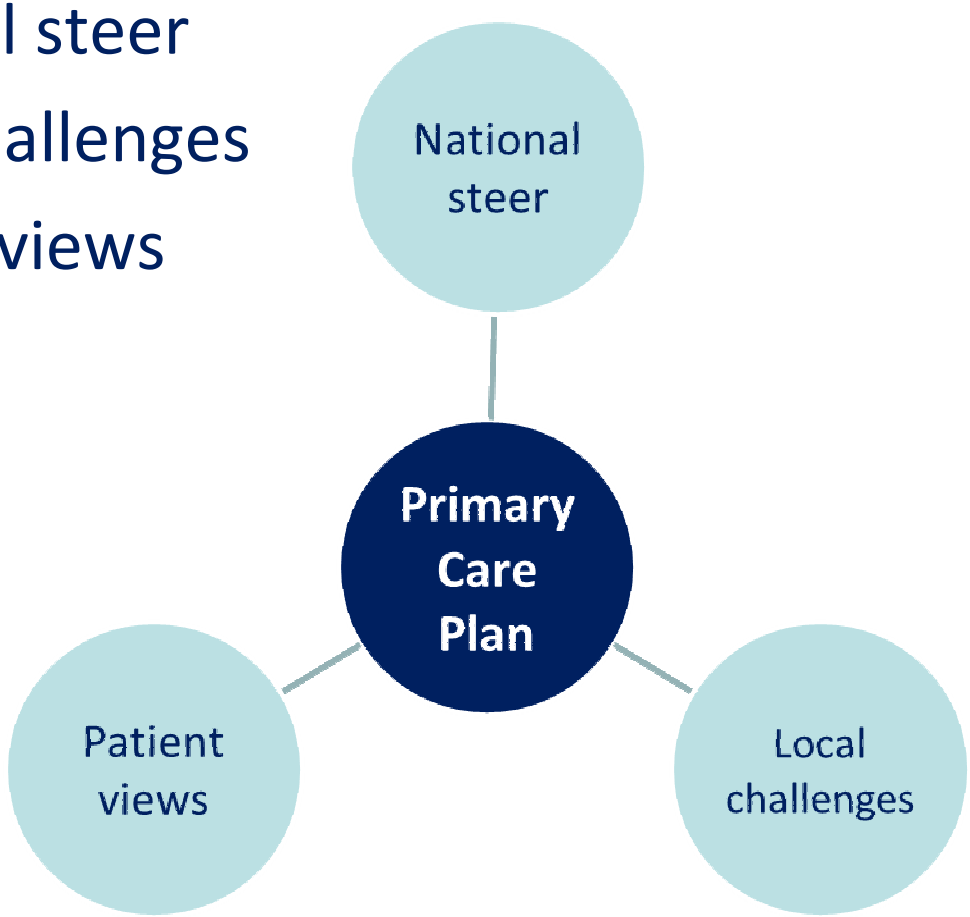
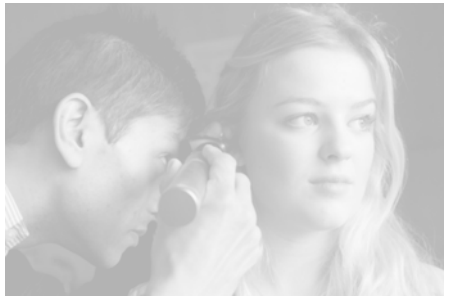
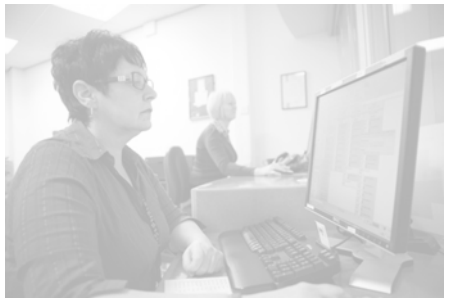
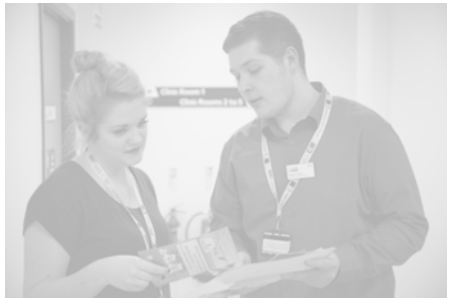
Our approach

- National steer
- Local challenges
- Patient views









National steer

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- Access 8am-8pm, Weekend working
- Flexible access including email, Skype and phone consultations for those who might prefer it to face-to-face, when it is safe to do so
- Easier, on-line registration and choice of practice
- Joining-up of urgent care and out-of-hours care to ensure rapid walk-in access to care
- Greater flexibility about how people access general practice, for instance with the option to visit a number of GP surgery sites in their area
- Better access to 'telecare' to help people stay comfortable at home, as well as to healthy living apps

- Improving outcomes
- Strategic and operational plans
- Allocation for CCGs
- The tariff
- Integrated Transfer Funds
- Developing integrated plans
- Working together
- Competition
- Local innovation
- Intermediate actions

- Named GP for over 75s
- Quality monitoring for out –of-hours (GPs who have opted out)
- Care plans
- Use of NHS number
- Online appointment booking
- Patients to order repeat prescriptions online
- Extended hours - extended with flexibilities to allow practices to work together to provide the most appropriate service for their patients
- Avoiding unplanned admissions enhanced service (case management, timely telephone access, shared information and data, GP2GP, discharge review, unplanned admissions review)

Local challenges

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- Transient and aging population
- Variations in access to primary care medical services
- Variations in clinical quality and patient health outcomes
- Variations in service delivery (LESs, access etc)
- Variations in the quality and size premises from which primary health care is delivered

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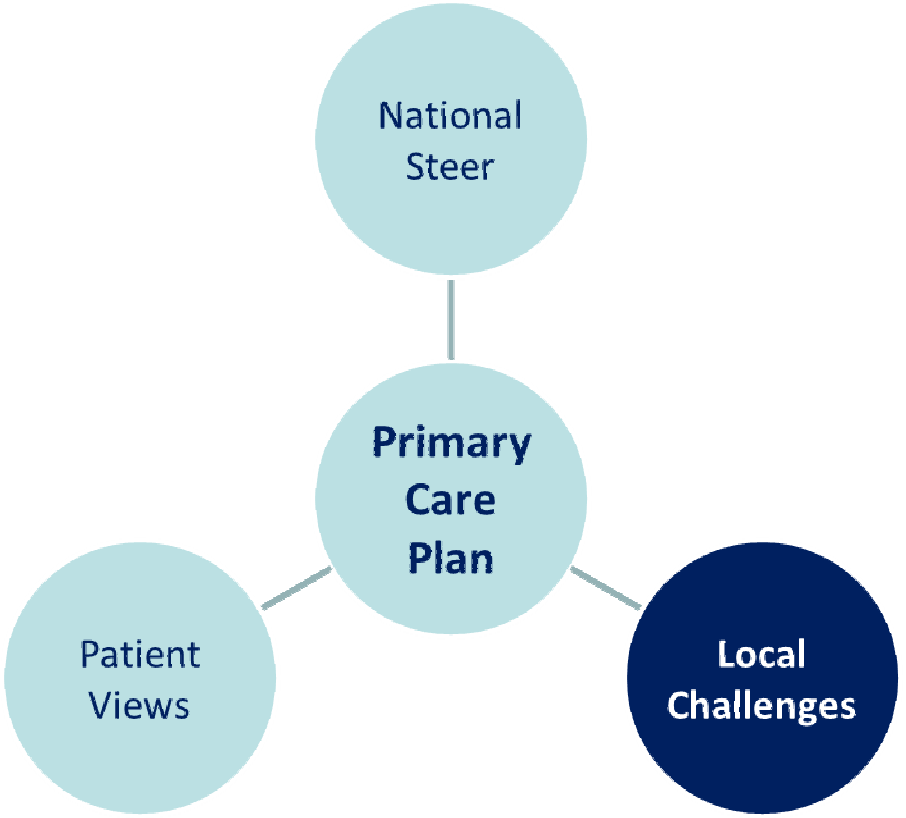
- Workforce concerns - shift in work but not in resources or funds
- Financial management / competition / contract changes
- Communication overload
- Workforce retention, retiring GPs, shortage of primary care clinicians
- Variations in service delivery/community services
- Managing patient expectations



Patient Views 600 surveys returned

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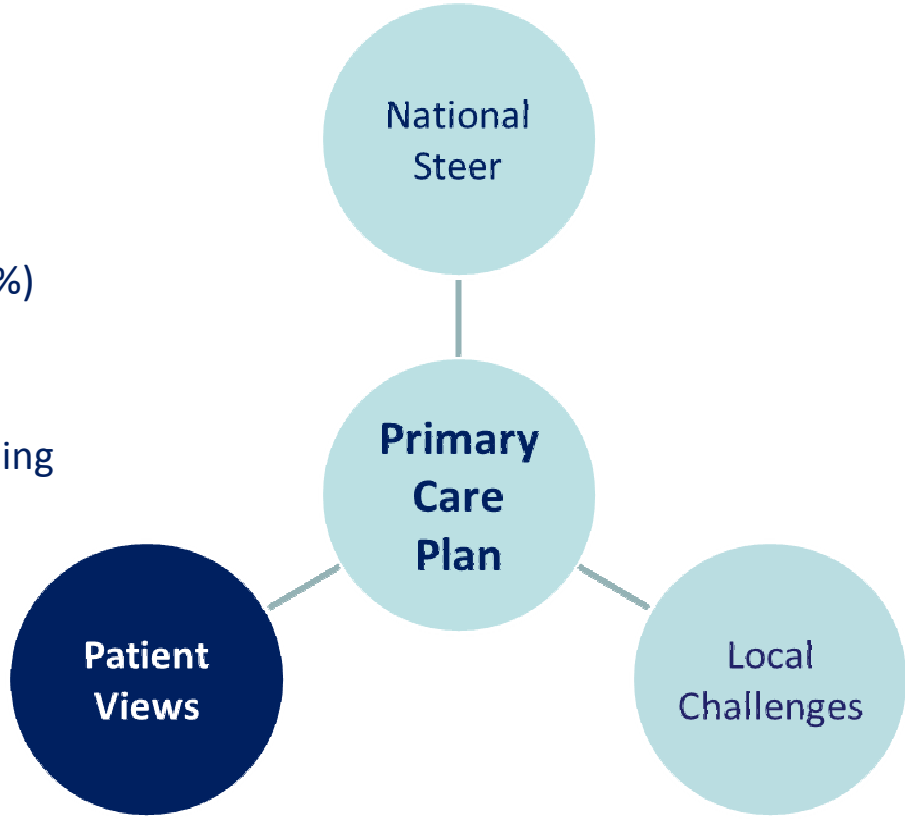
Access

- Large support for GP telephone contact (312 - 65.7%)
- Happy for receptionist to signpost to nurse (under guidance)
- Consistency of approach of access (324 - 74%)
    - Urgent appointments same day (259 - 59.3%)
    - Routine appointment up to 3 days (147 - 33.6%)
    - Routine appointment bookings 2 weeks in advance (110 - 25%)
    - Sit and wait drop-in clinics (rather than attending ED)
- Saturday opening (339 - 77.6%)
- Sunday opening (110 - 25.2%)



General feedback

- Flexibility of named GP, when urgent/same day
- Consistency required for LTC on-going treatment
- appointment required. (49%), (29.7% yes if LTC related)
- Would like to see more use of technology
- All NHS resources should have Shared technology/data

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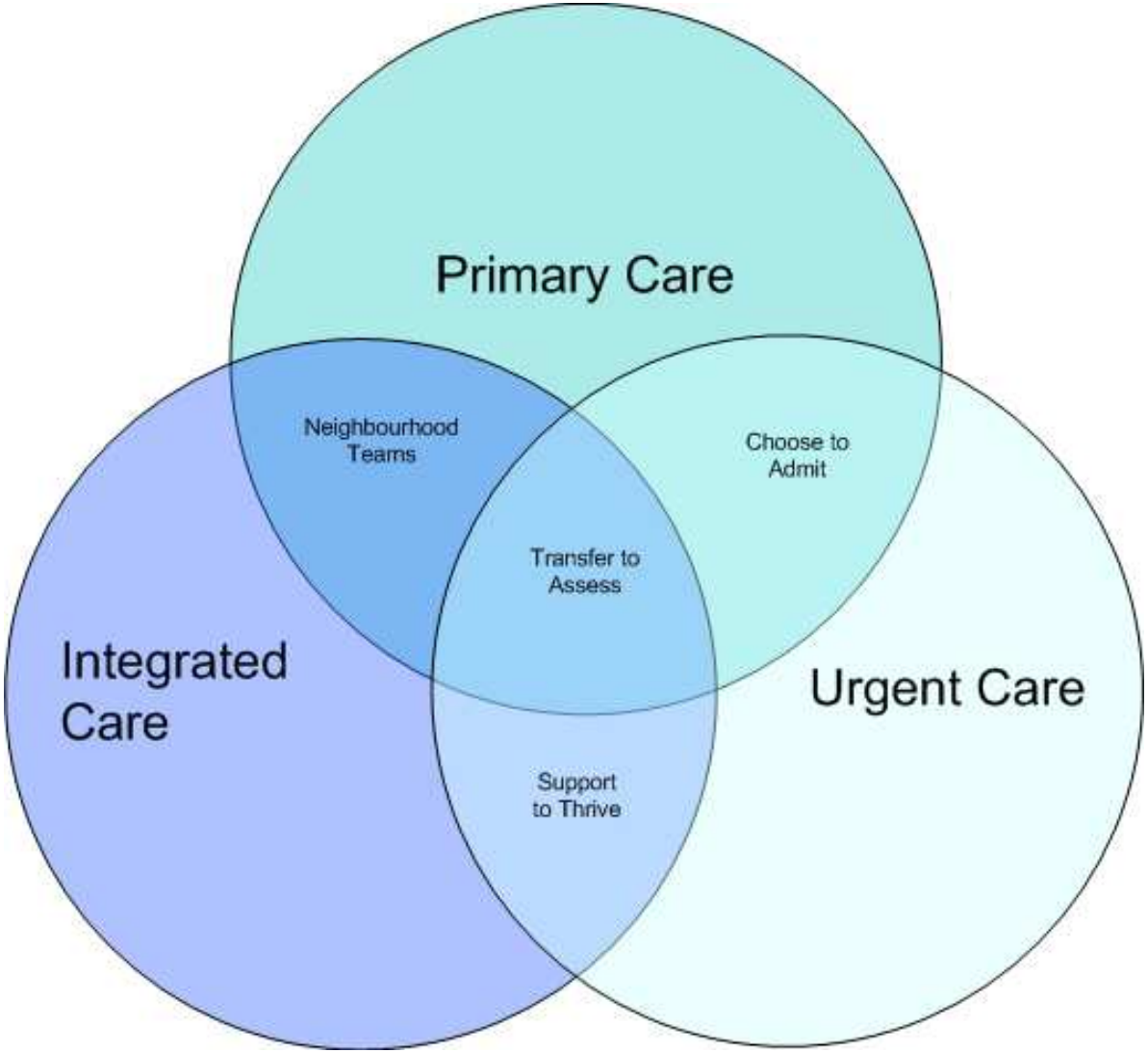
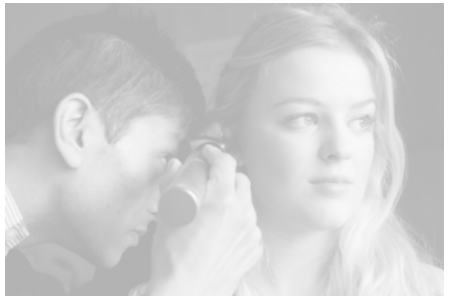
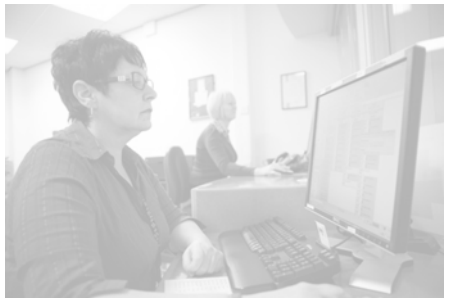
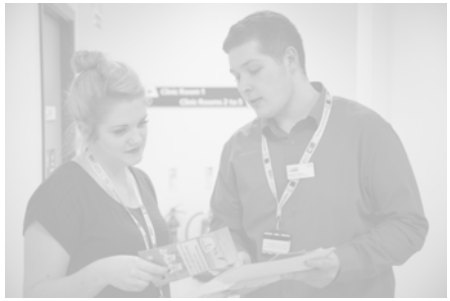
Relationships to Consider









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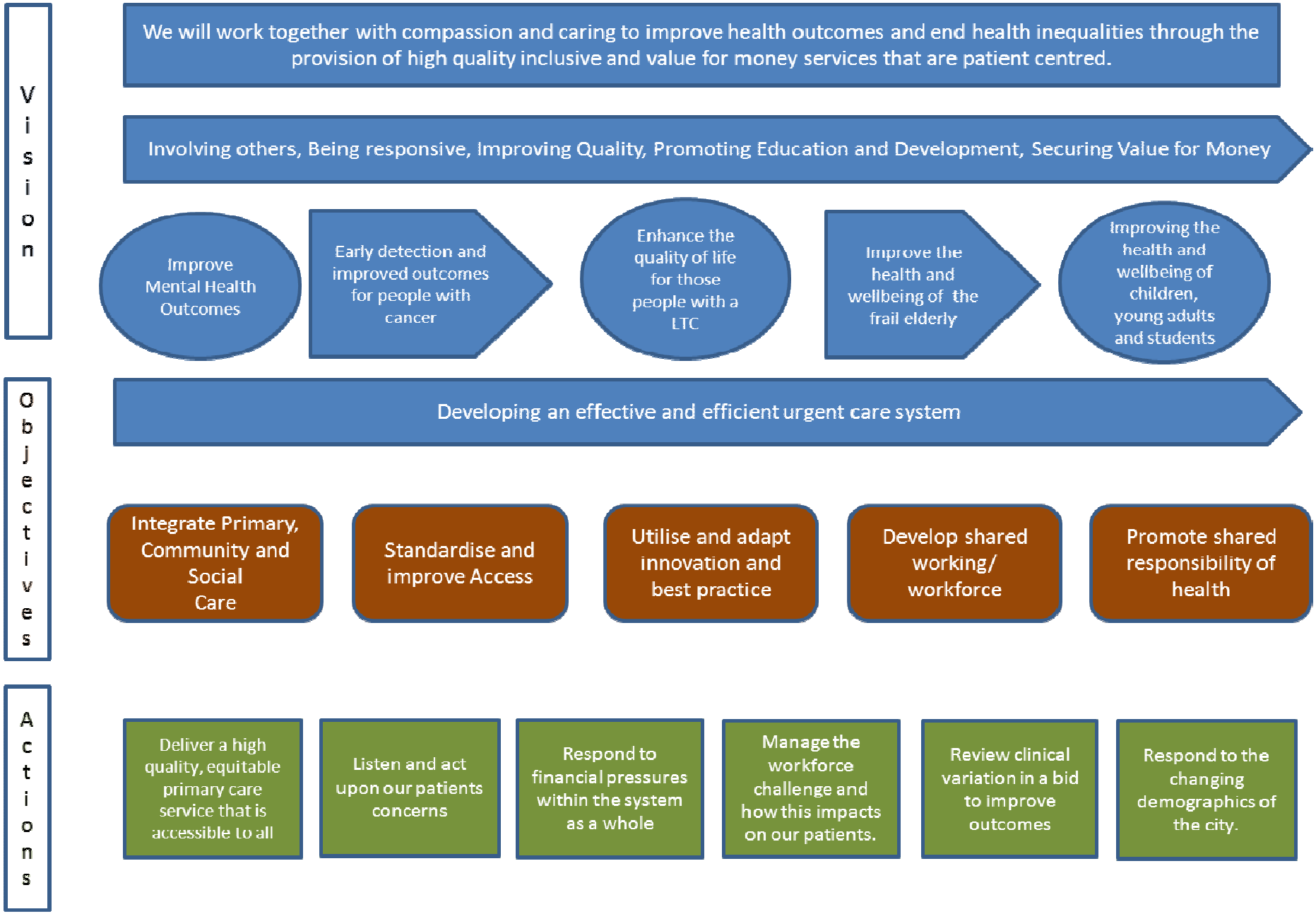
Primary Care Vision
Plan on a Page


Vision
We will work together with compassion and caring to improve health outcomes and end health inequalities through the provision of high quality inclusive and value for money services that are patient centred.
Involving others, Being responsive, Improving Quality, Promoting Education and Development, Securing Value for Money
Improve Mental Health Outcomes
Early detection and improved outcomes for people with cancer
Enhance the quality of life for those people with a LTC
Improve the health and wellbeing of the frail elderly
Improving the health and wellbeing of children, young adults and students
Objectives
Developing an effective and efficient urgent care system
Integrate Primary, Community and Social Care
Standardise and improve Access
Utilise and adapt innovation and best practice
Develop shared working/ workforce
Promote shared responsibility of health
Actions
Deliver a high quality, equitable primary care service that is accessible to all
Listen and act upon our patients concerns
Respond to financial pressures within the system as a whole
Manage the workforce challenge and how this impacts on our patients.
Review clinical variation in a bid to improve outcomes
Respond to the changing demographics of the city.

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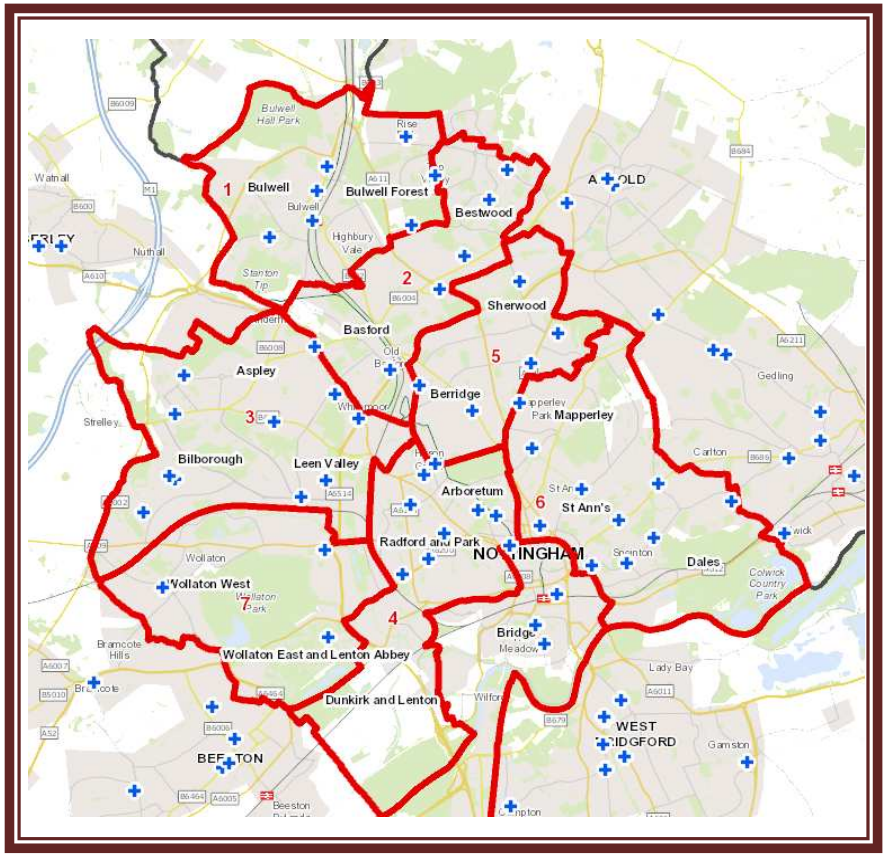
How will the vision be achieved?

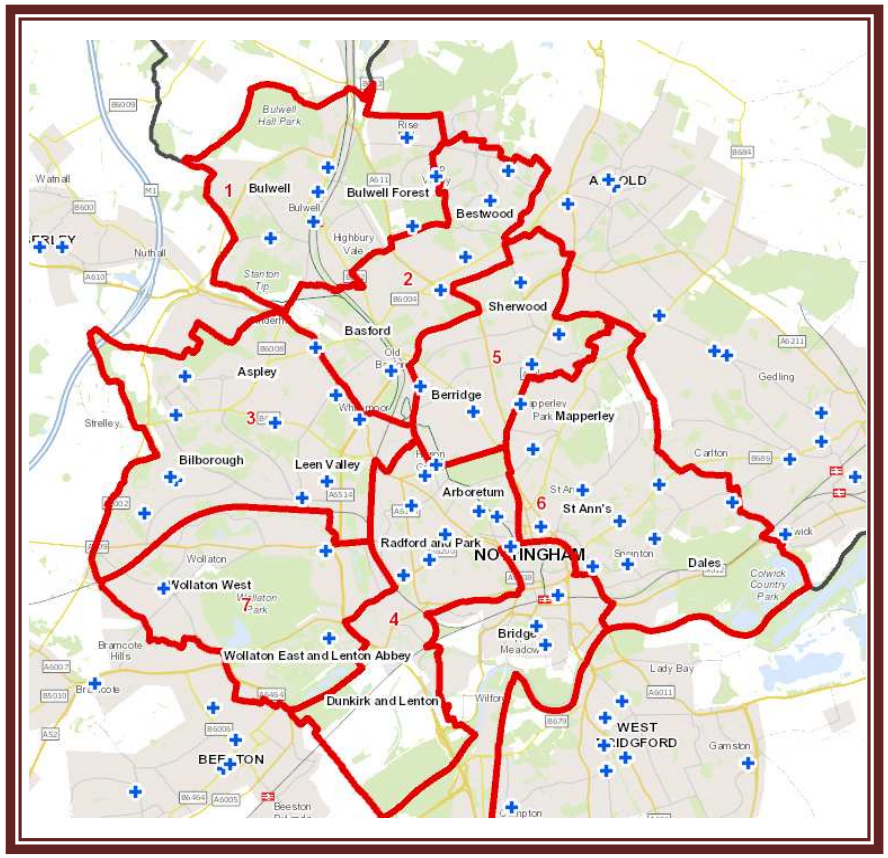
Integrate Care

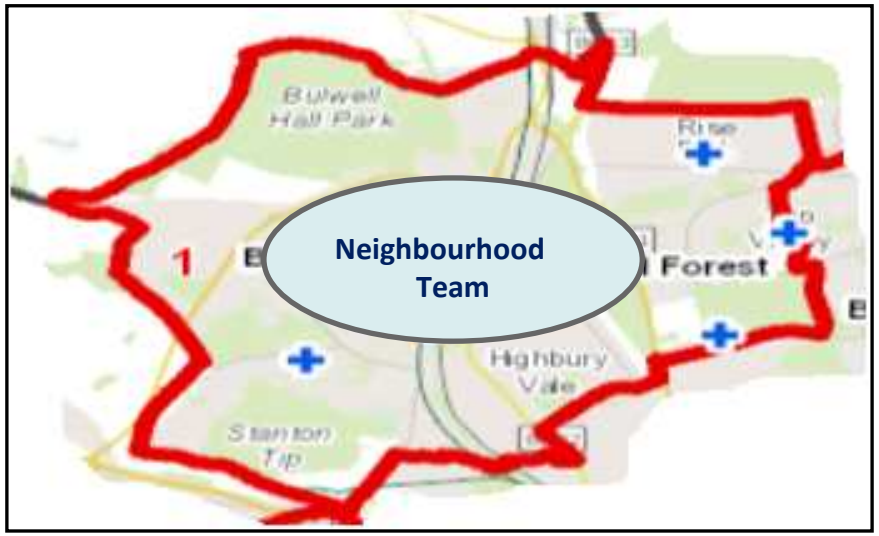
- Alignment of GPs within care delivery groups with LA including neighbourhood teams
- Implementation of Care Co-ordinators to underpin and support CDGs.
- Implementation of management MDT management of patient care
- Promotions of shared working and workforce to alleviate current local and national pressures.



Innovative use of IT and Technology

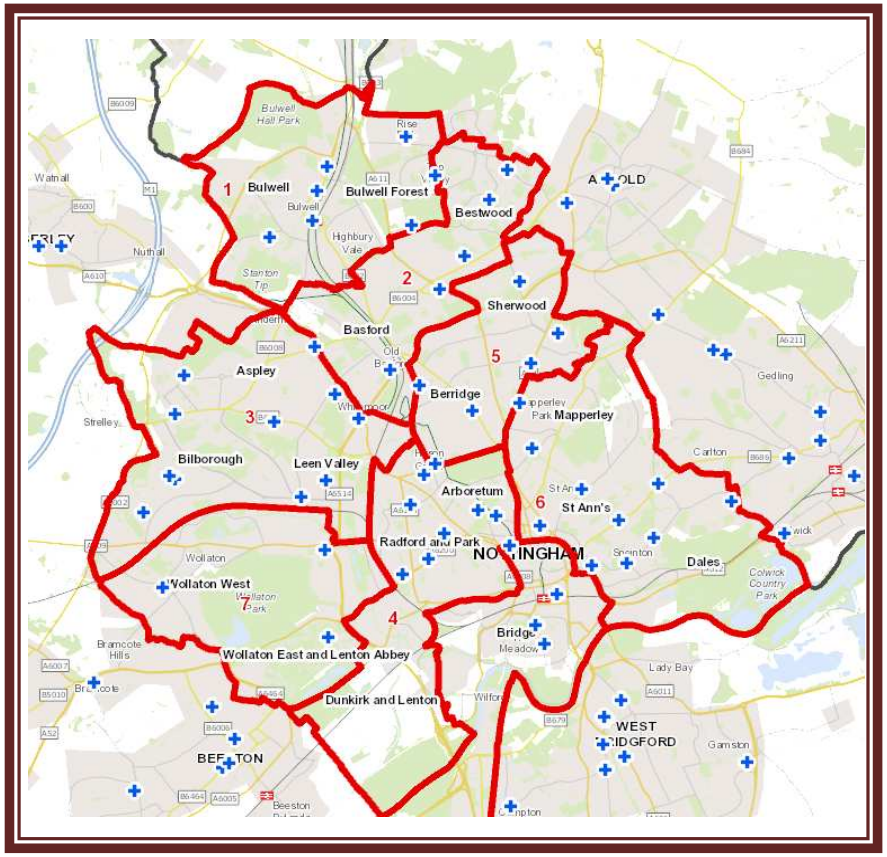
- Commissioning of Interoperability gateways to support and enable Information sharing between organisations
- Promotion of NHS number between health and LA
- Continued promotion of Innovative systems such as Electronic Prescriptions, Sunquest ICE, online patient records
- Promote Mobile working
- Remote visual Consultations
- Assistive Technology / Innovative Technology
  - Online Booking
  - Skype
  - Telehealth
  - Telemedicine

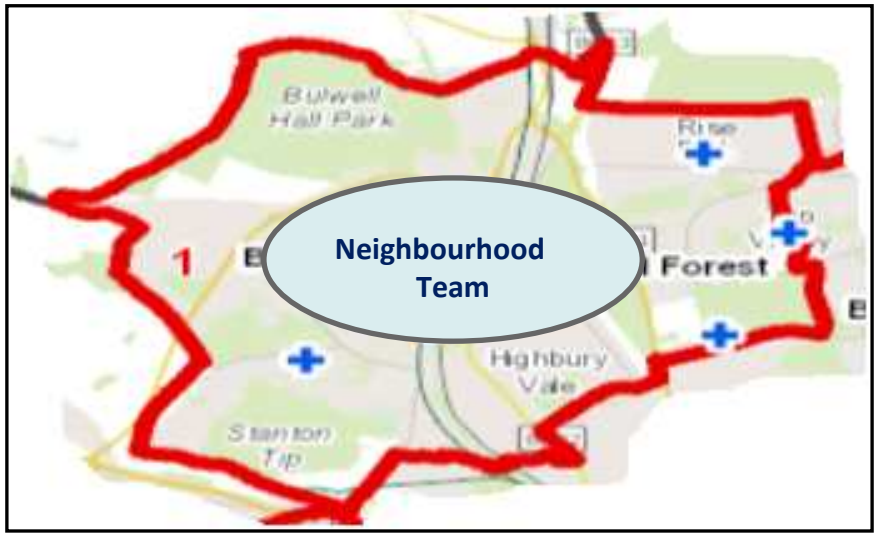




Standardize access and improve quality

- Standardise approach / aspirations
  - Standardise access (1 day urgent, 3 day routine)
  - GP First/triage system
  - First line physio
  - Sit and wait ‘drop in’
  - Promotion of self referral services
  - Utilisation of AQP for generals services to ensure equitable access and quality
- Development of Pathways website
- Development of 7 day working at CDG level**
- Acute (Home) Visiting Service
- Assistive Technology / Innovative Technology
  - Online Booking
  - Skype
  - Telehealth/Telemedicine

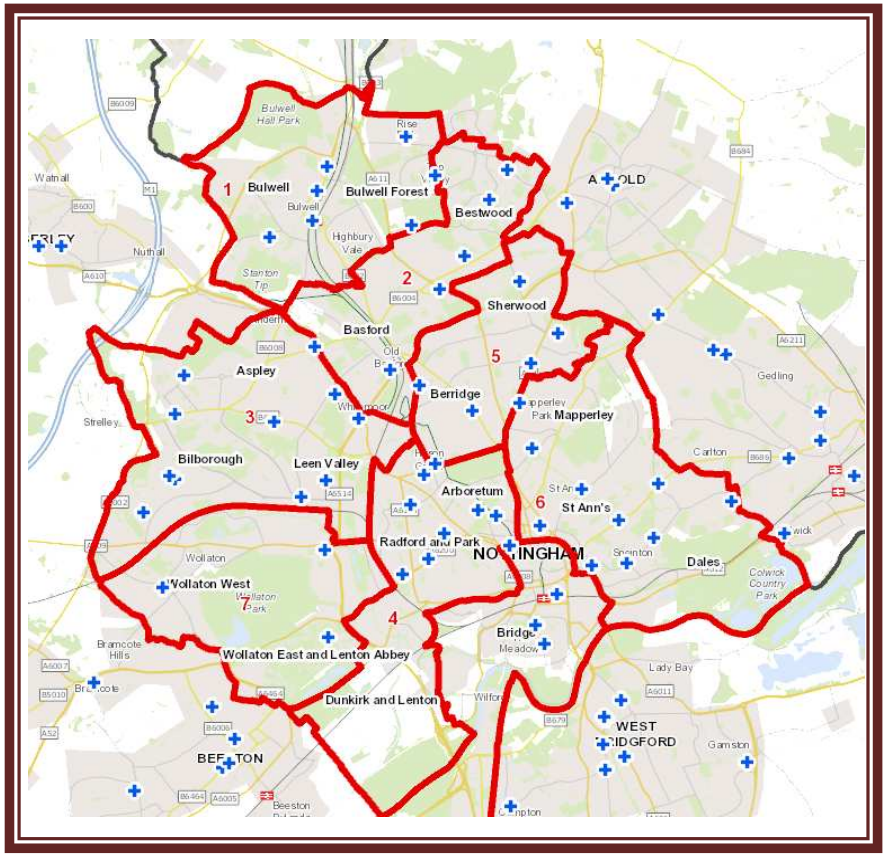


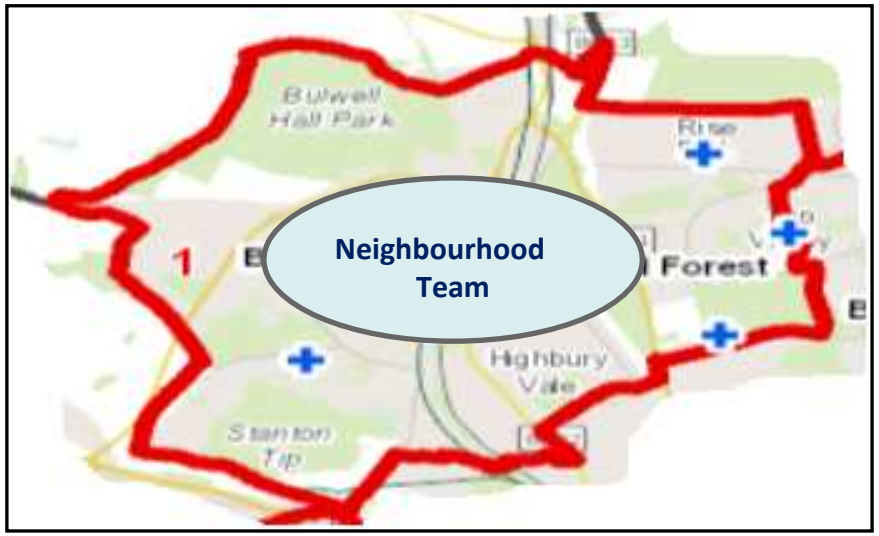


Shared working/learning

- Pilot of GP communities/Federations and alliances
- Working with LMC to develop primary care infrastructure

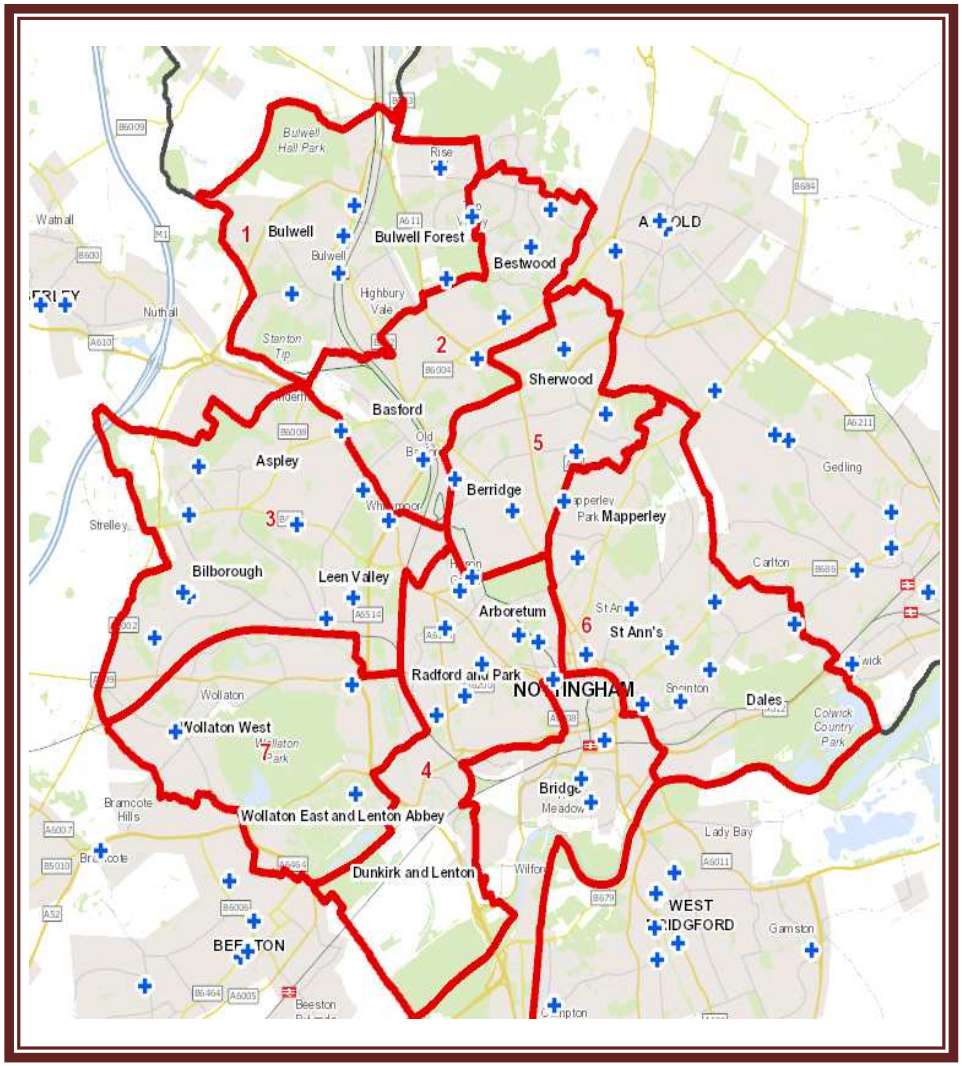
- Practice Visit programme
- Protected Learning Times
- Practice Manager development/forums
- Reception training
- Practice Nurse development/forums
- Responsiveness contract





Promote shared responsibility

- Communicate responsibility of managing resources in health, (cancelling appointments, using right services, using ED).
- Commission self referral services, physiotherapy, podiatry, pain management, IAPT
- Create self help advice and support within each practice



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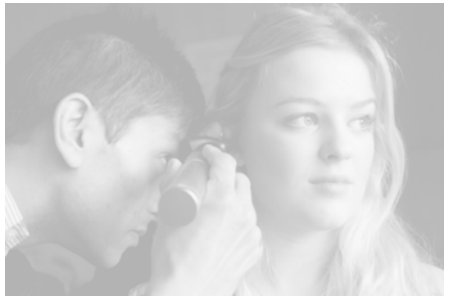
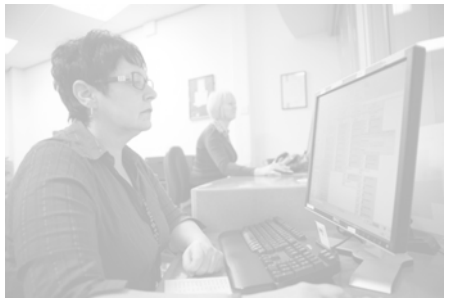
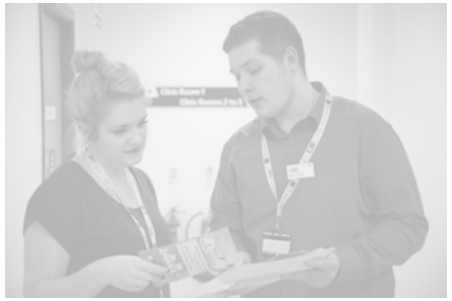
How will this be funded?







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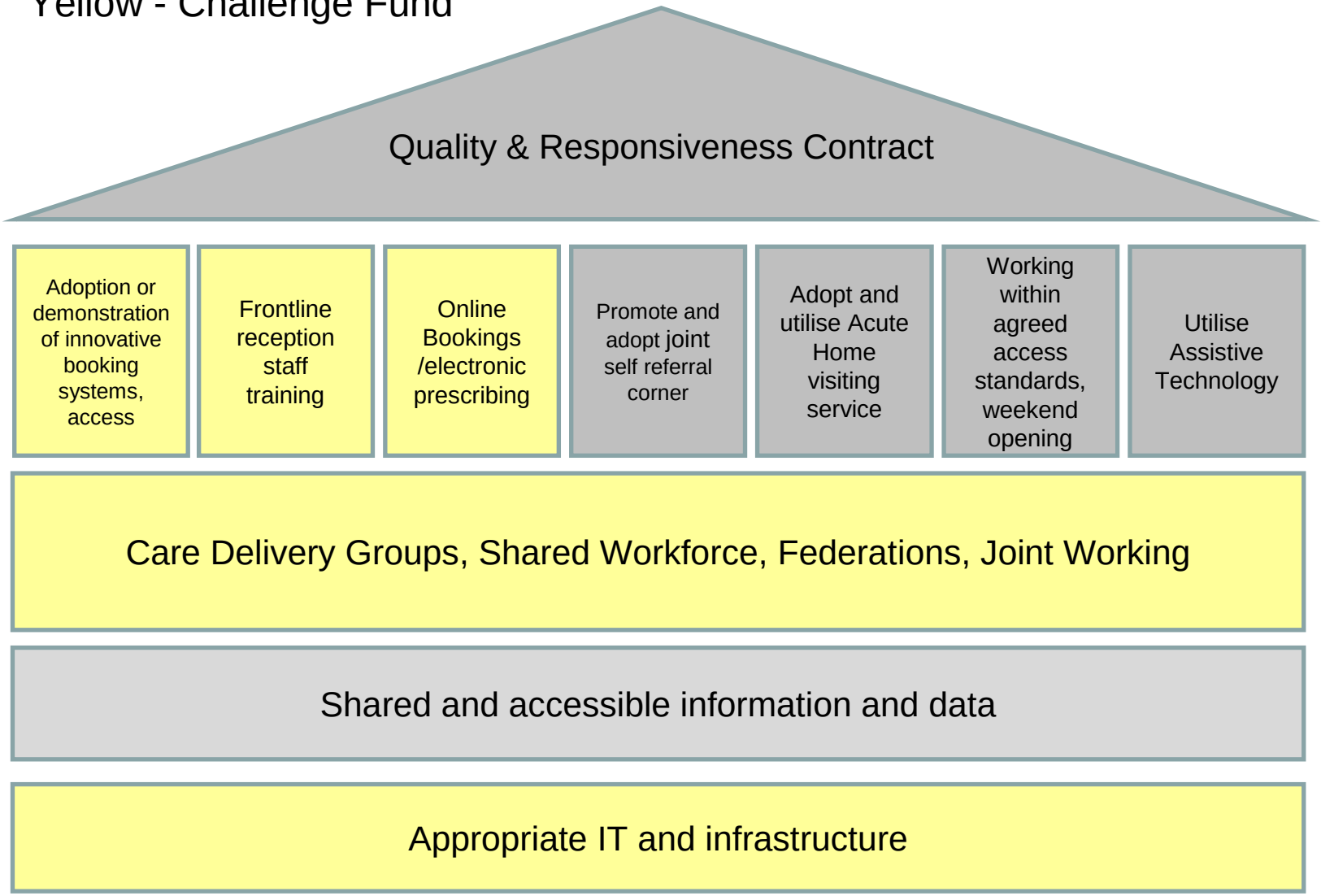
Grey - Non recurrent CCG
Yellow - Challenge Fund



What will success look like?

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Improved Primary Care access

•Uptake, usability, satisfaction

Improved patient outcomes

•Focus on self-care, clinical communities, and equitable care

Improved cost-effectiveness

•Earlier presentation, unnecessary interventions avoided

•Assist GP productivity, net savings on unnecessary interventions